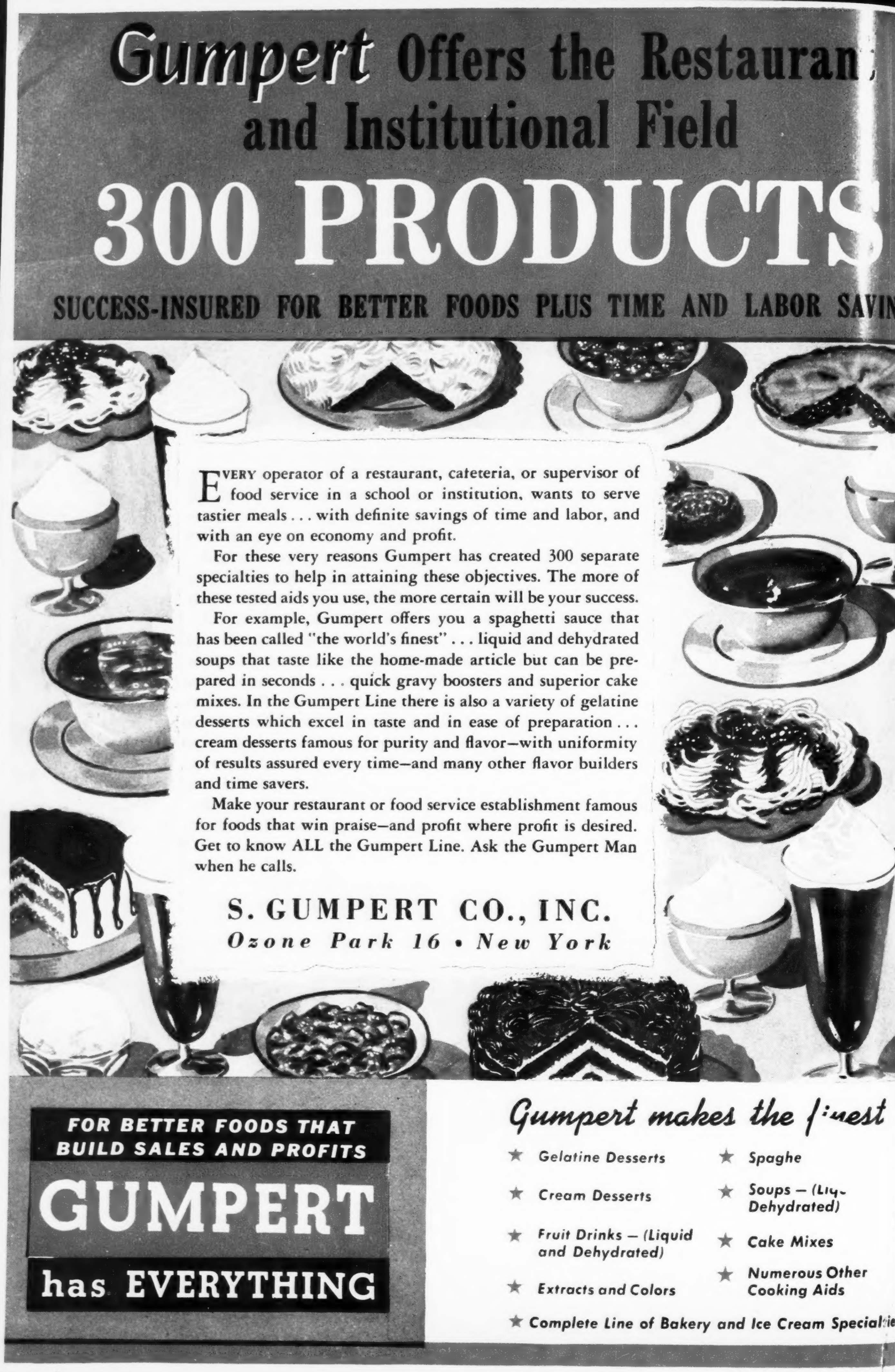
the MODERN HOSPITAL

VOLUME 66 MAY 1946 NUMBER 5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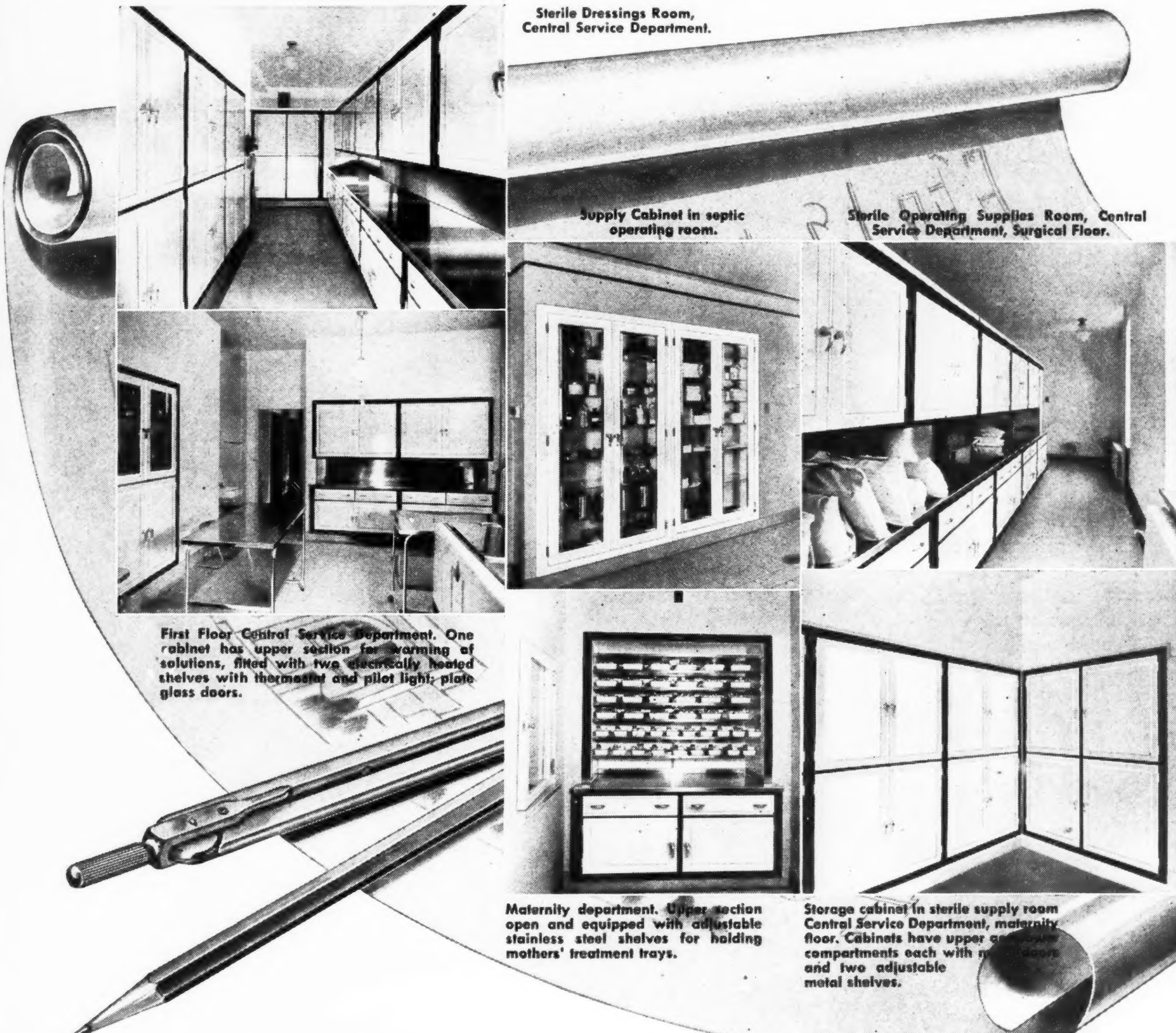

Sterile Dressings Room, Central Service Department.

Supply Cabinet in septic operating room.

Sterile Operating Supplies Room, Central Service Department, Surgical Floor.

First Floor Central Service Department. One cabinet has upper section for warming of solutions, fitted with two electrically heated shelves with thermostat and pilot light; plate glass doors.

Maternity department. Upper section open and equipped with adjustable stainless steel shelves for holding mothers' treatment trays.

Storage cabinet in sterile supply room Central Service Department, maternity floor. Cabinets have upper [illegible] compartments each with [illegible] doors and two adjustable metal shelves.

RECESSED CABINETS

Important factors in planning the modern hospital— Specify Scanlan-Morris

Typical of the trend in the planning of modern hospitals are these photographs of Scanlan-Morris recessed cabinets built into St. Nicholas Hospital, Sheboygan, and St. Alphonsus Hospital, Port Washington, Wis. In addition to the cabinets shown, other Scanlan-Morris cabinets in these hospitals are:

1. Recessed combination cabinet for storage and for warming of solutions and blankets — in main corridor of maternity department near Central Service Room and delivery rooms.
2. Recessed supply cabinets in unsterile work room, Central Service Department, surgical floor.
3. Recessed supply cabinet in surgical corridor.
4. Recessed cabinets in splint room, surgical floor—three equipped with swinging type harness hooks for splints and fracture equipment; others with metal shelves and plaster barrel compartments.
5. Recessed cabinets, counter type, in unsterile work room of Central Service Department—stainless steel counter tops.
6. Counter type cabinets for soiled utensils, equipped with double sink—in maternity department.

Scanlan-Morris recessed cabinets, each cabinet custom built from plans and specifications covering the individual requirements of the hospital, are installed in many leading hospitals.

The cabinet bodies are made of 20 gauge furniture steel. All corners are made with double lapped and sweated seams, insuring dust-proof construction. Frames are flat teel, electrically welded to insure maximum strength and rigidity. The cab'nets may be finished in any color to harmonize with the color of walls and other equipment. Fittings are finished in nickel plate or chromium plate, as specified.

Years of designing and manufacturing experience and contact with surgeons, hospital superintendents, engineers and architects, qualify our Technical Sales Service Department to give valuable assistance and authentic guidance in hospital planning. Suggested layouts supplied without obligation.

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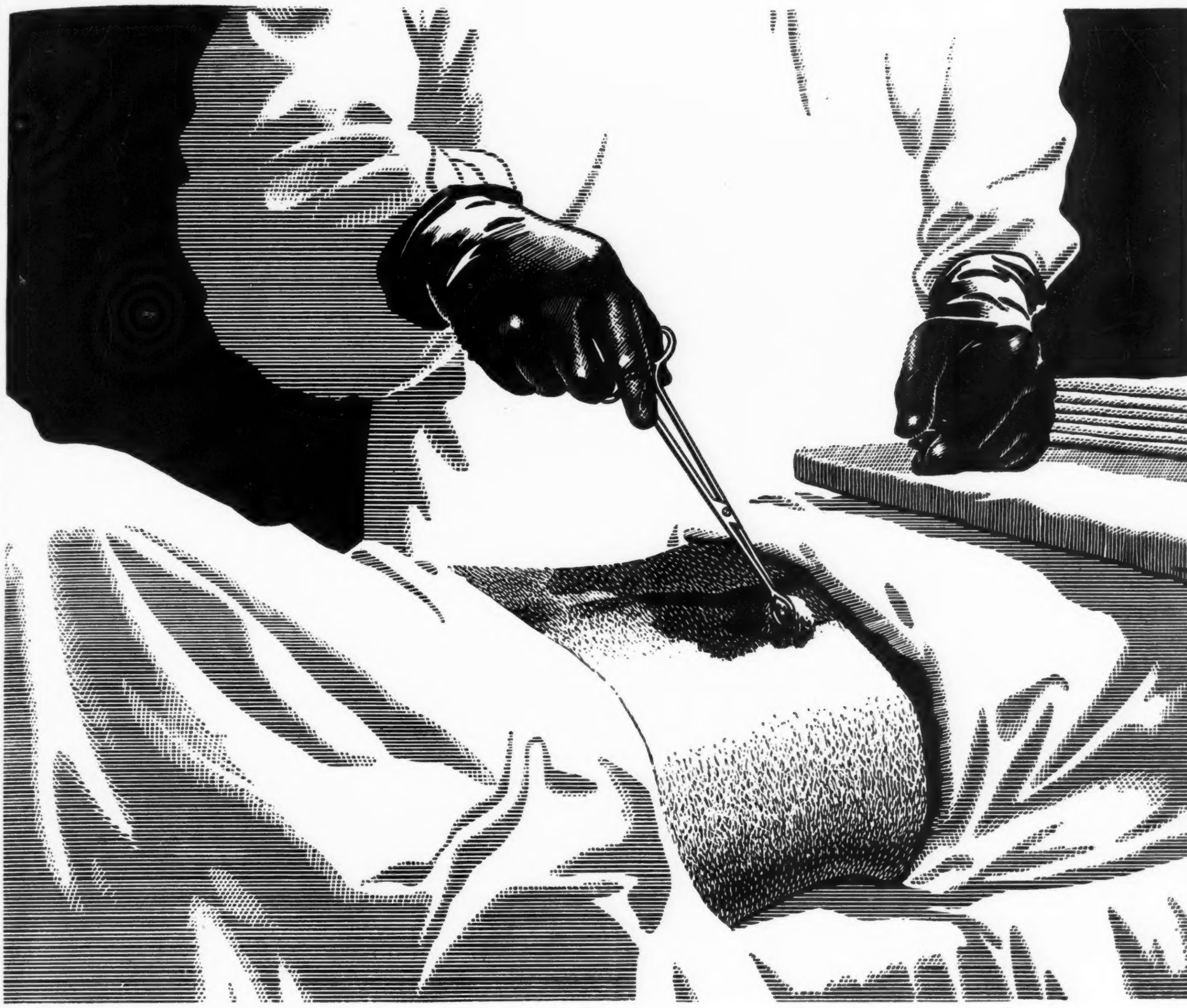


Thanks for Service

Directors of Memorial Hospital, Lynchburg, Va., have recognized with substantial gifts and notes of appreciation the long periods of service of Lillian E. Van Pelt, R.N., the superintendent, who has been connected with the institution for forty years, and of eight others who have been there for twenty or more years.

Seven additional members of the hospital household have served an aggregate of eighty-two years, making a total of 324 years' service on the part of these 16 employes.

Miss Van Pelt served Memorial Hospital first as operating room supervisor, then as assistant superintendent and for the greater part of the time has held her present job of superintendent.

Others who have served more than twenty years and received $100 checks and a note commending them for "long and efficient service" from the board of directors are:

Nancie Forgie, R.N., anesthetist, thirty-two years; Mrs. T. M. Thompson, R.N., instructor of nurses, twenty-six years; Mrs. James Irwin, bookkeeper, twenty-six years; Eva Emerson, graduate nurse-technician, and Myrtle Arthur, R.N., dietitian, twenty-two years; Ruby Padgett, R.N., night supervisor, twenty years; Ed Early, orderly, twenty-nine years, and Booker T. Washington Young, cook, twenty-two years.

Hospitals, Take Note

College history was made with the recent adoption of a new policy regarding the compensation and working conditions of nonacademic employes of the University of Illinois. Since this institution's new regulations apply to employes of Research and Educational Hospitals, Chicago, they will be of vital interest to hospital administrators.

Described as a model labor policy, this one frankly accepts the principles of collective bargaining. On the other hand, it expresses a firm intention to treat all employes consistently. No employe has to join a union to get his full rights and no employe is deprived of any rights because he joins a union.

Prevailing rates of wages are paid under the policy and changes in rates are followed as closely as possible in the operating and service areas and in the building trades.

Merit ratings enter into about 80 per cent of the positions; this system takes into account outside salary practices and uses a job evaluation procedure.

Standard working schedules are a part of the policy. The university hopes soon to put all of its employes on a five day work week. The principle of premium pay for overtime beyond that regularly called for on the schedules is a part of the policy.

Training courses, paid vacations of at least two weeks and two weeks' annual disability leave with full pay are provided. Machinery is set up to handle grievances.

The nonacademic employes now have their own monthly publication entitled the *Illini Worker,* the first issue of which came out last January. It is a three column, eight page house organ printed on slick paper.

An article treating of this university's new personnel policy will appear in The Modern Hospital in the near future.

1945 Dec.12,
Dear Head Nurse,
I am very sorry for being So bad in The Hospital for doing the WILD things I did. I hope you will please forgive me, and also give my Apology To the other nurses Who were so kind. I guess I didn't Know how quiet I was Supposed To be. I Shouldn't have disturbed the Others and caused the nurses so much trouble. I'm not allowed to act that way at home.
I promise if I ever Come back that I will behave better. You were ALL So nice to me, and I say again I'm sorry.
Love,
Bruce
Owens

Bruce Is Sorry

Among much prized letters from former patients, Nassau Hospital, Mineola, N. Y., gives the one shown at the left from a 7 year old a high place.

Menninger Takes Steps

"Galluses provide a sour note and are frowned upon for the professional staff, when coats are off in extremely hot weather."

The foregoing paragraph shows how explicit are the instructions given in "Steps in the Right Direction," the new mimeographed employes' manual issued by the Menninger Foundation, the internationally known Kansas institution for the examination and treatment of mentally ill patients and for research.

A loose-leaf manual, its contents are divided into three parts. Step 1 is called "Your Job and Its Future" and it gives information about pay days, working hours, over-time pay, deductions,

job evaluations, promotions, resignations and dismissals, meals, parking, the health program, sick leave, holidays, vacations, housing, library and recreation, with little drawings to enliven the pages and divide the subject matter covered.

Step 2 is titled "You and Our Patients." Even more readable than Step 1, it discusses relationships with mentally ill patients, what being "friendly" with them connotes, the guarding of confidential information, how to answer questions about patients, regulations against carrying matches or leaving instruments of self-destruction lying about, the procedure when patients offer gifts and on what factors rates for treatment are based.

Step 3 is called "You and Your Job" and tells of job instruction, what to do when you are troubled, confused or angry over things that come up, regulations against personal callers, rules about telephone calls, telegrams and mail, recommendations for dress and for formal address of other workers, rules about smoking and gum chewing and tipping, a warning to release news stories through the public relations department only.

It is such an informative, friendly and comprehensive job of work that institutions for the physically ill will find the manual helpful in planning a similar handbook for employes.

Redbirding Comes to Carville

A colorful word in our American language that H. L. Mencken ought to hear about is "redbirding."

Now what could redbirding be connected with except romancing? Let the hep-cats chant their jive, such as "gleam-beam," but give us a resplendent term like "redbirding" every time, sad as its connotation.

"Redbirding" originated when first boy loved girl only to learn that the course of true love never runs smooth, but as a term it came into usage many years ago at the National Leprosarium at Carville, La. Today, redbirding still occurs for the chase is beset with hazards when males outnumber females 3 to 1 as they do at the U. S. Marine Hospital at Carville.

When boy takes a fancy to girl at Carville, his first gesture, according to a reporter on the *Star*, the patients' own paper, is to order a red necktie from the Sears, Roebuck catalog. Thus, arrayed in the armor of love, he starts a campaign of conquest.

But there are other flashy neckties about and the girl does not announce to the community that she has made any real choice until she appears with the boy at the movies one evening. Going to the movies with a fellow patient at Carville is tantamount to wearing an engagement ring elsewhere. Disheartened by her avowed preference, the other boys cast aside their red ties or turn their attentions elsewhere.

But suppose our boy and girl get to redbirding. The others then take heart, don their bright ties and resume the chase.

According to the *Star*, the term "redbirding" goes back to a period in the hospital's history when the fellows actually trapped redbirds when on the outs with the girl friend. What consolation they found in this diversion no one seems to know. We turn that problem of etymological research over to the sage of Baltimore.

Fewer Scandals Expected

Hospitals make the "front page" oftener through error than through design, unfortunately. A surefire newspaper scandal breaks whenever a voluntary hospital allegedly fails to treat or recommends too early transfer of the indigent victim of an accident.

Chicago has had its share of bad hospital publicity from such occurrences. The chances for a repetition of such newspaper scandal declined the day the emergency rules committee of the Chicago Hospital Council adopted rules to

guide its member hospitals in the admittance and care of emergency cases.

First, the council's committee, with Veronica Miller of Henrotin as chairman, wrote down four conditions that require first-aid treatment. These are (1) shock, (2) hemorrhage, (3) fractures and (4) pain.

The principles adopted as a guide by the Chicago council boil down to four:

1. A licensed physician must supervise the emergency examining room.

2. Hospitals must accept all patients coming for emergency treatment regardless of financial circumstances, race, creed or color. When hospitalization is not indicated, the determination must be made with the approval of a licensed physician.

3. No patient shall be discharged or transferred to another hospital except with the approval of a licensed physician.

4. Each hospital may develop individual rules covering procedures in accordance with its own hospital policy.

Columnist Does His Bit

Those local newspaper columnists who have a set space to fill every day of the week sometimes run pitifully low on ideas. That's why the mortality rate is high among columnists. After a time they are on a starvation diet. They never think, unless fate intervenes and hospitalizes them, that there may be a wealth of human interest in their hometown hospitals. Or perhaps the hospital superintendent is afraid to risk the use of these smarty-pants boys and girls of the city room as hospital ambassadors of good will.

In Minneapolis sometime back, a distraught columnist, probably as a last resort, called his friend Nellie Gorgas at St. Barnabas Hospital to see what was cookin'. Now Nellie is a lady who could write a column of her own, no doubt. She took the time to give this young man some factual and entertaining information.

The result was an entire column compounded of stray facts and stories of patients' and visitors' foibles that made first-rate copy. That fifteen minutes with a desperate columnist may have been of greater public relations value to the hospital than 10 books on visitors' rules or a stuffy annual report.

Among the Guests Were—

They came in their best bibs and tuckers, honor guests of the hospital they had served so long.

Ezekial Reeves, the head janitor, was there, proud that his thirty-nine years of housecleaning was being recognized.

Margaret Orgel, a kitchen helper for thirty-two years, was there and recalled the turmoil in the flooded kitchen the day a cyclone struck the old hospital building.

Dee Hutt, meat cutter and chef for twenty-five years, came, too, sampling his own cooking with a new relish.

Arlie Greenemann, president of the National Association of Power Engineers, was a guest. Arlie, now chief engineer, entered the hospital employ as a boy, 23 years ago.

Fred Wilson little dreamed as a boy in Ireland that one day he would become laundry supervisor in a hospital across the sea; yet his twenty-three years with the hospital had passed all too quickly.

These five employes, honored for more than twenty years' service with Deaconess Hospital, St. Louis, shared acclaim with three deaconesses who have served the hospital for a quarter century.

Other guests of the board of trustees at dinner in the hospital auditorium one evening in March were 46 other employes of Deaconess who had served the hospital more than five years in one capacity or another.

In fact, Rev. Paul R. Zwilling, the superintendent, was able to point out that 40 per cent of the institution's lay employes have served more than five years—quite a record considering the job opportunities available during the war years.

READER OPINION

To Help the Mentally Ill

Sirs:

Several of us who have children in state and private mental disease institutions are forming a nonprofit corporation for the benefit of our children. We have to have a larger group than we now have, and we thought you would be willing to help by informing more parents and guardians of the reasons why such an organization should exist:

1. State institutions are crowded. If some patients could be removed, the same appropriations would provide better care for remaining patients.
2. State boards cannot remove patients, but parents or guardians can, if there is some place to take them.
3. This nonprofit corporation would give these parents a chance to provide better care at cost. Many parents hesitate to place children in private hospitals run for profit for fear care will be worse than at state hospitals.
4. Psychiatrists are favorable to the plan, since it would encourage better results in treatment.
5. Mental illness is increasing. Here is a means of providing better care for more patients.
6. For their own good and the good of the community the mentally ill must be cured whenever possible. If they cannot be cured, humane people wish them to have the most happy surroundings possible.

For all these reasons, we hope you will help us get in touch with other parents and guardians of the mentally ill.

Mary Bass Wetmore

Wichita, Kan.

News From China

Sirs:

It is good news to know that this hospital will again receive The Modern Hospital. During the Japanese invasion there were no mail and no postal system for eight months, and no magazines from the U.S.A. for four years.

It will be refreshing to see new magazines once more, but we may be discouraged when we compare our present makeshift methods with the modern hospital. So much of our equipment was carried away by the Japanese, or damaged by them, that we have had to resort to primitive methods. The gauges were stolen off the big steam sterilizer so that we are reduced to one little 30 year old pressure sterilizer worked with a charcoal flower-pot stove.

Lora G. Dyer, M.D.
Acting Superintendent
Willis F. Pierce Memorial Hospital
Foochow, Fukien, China

Sun Never Sets . . .

Sirs:

We have just received a letter from the Charities Board of Victoria, Melbourne, Australia, referring to your November issue, which carried the story of our rules concerning visitors. In accordance with this letter we are sending copies of the rules along with a letter about our experience.

I thought this evidence of the effectiveness of your widespread circulation might be of interest to you.

Robert G. Whitton
Administrator
Alexandria Hospital
Alexandria, Va.

Shucks, Fellas!

Sirs:

I have read your editorial page with pleasure and profit for some time—I consider it a highlight of this excellent publication.

Nevertheless, as one who has worked at this writing business for more than twenty years, I feel impelled to say "Orchids to you!" for your editorial entitled "One Purse" in the March issue. Not only is it a valuable comment on a timely subject, but by all the standards I have ever learned it is a most excellent piece of editorial writing.

C. R. Nelson, D.O.
American Osteopathic Association
Chicago

Sirs:

I have been a reader of your magazine for several years, but never, in my opinion, has it contained as many outstanding articles and contributions as in the March 1946 issue. The variety of interest and the appeal of all the articles are what make me believe this issue is so important to the administrator, trustee, student and various department heads. I hope you will continue to publish such outstanding articles.

Paul M. Cole
Gardiner General Hospital
Chicago

Sirs:

We have just received our copy of your March issue and we wish to congratulate you sincerely on the marvelous job you have done in presenting not only the Kahler Hospital material but the other projects also. Your new style is, to say the least, exceedingly effective, and I am sure it will elicit from your readers much more interest in architectural presentations.

Thomas F. Ellerbe
Architect
St. Paul, Minn.

LOOKING FORWARD

No Answer

AS HEARINGS on the Wagner-Murray-Dingell Bill opened in Washington with Taft *vis-à-vis* Murray in one of those charming exchanges that distinguish the official conduct of our legislators, the American Medical Association let it be known that its approval of prepayment medical care plans would be given to insurance underwritten and sold by commercial companies, so long as such companies had the endorsement of appropriate county or state medical societies. In fact, an A.M.A. representative has urged that Blue Cross plans should join hands with commercial insurance in order to present the strongest resistance to the government program.

The illogic of this proposal is apparent in the disparate aims and atmospheres of Blue Cross plans and insurance companies. Probably nothing would encourage the proponents of government medicine more than to see the wholesome, "people's choice" complexion of Blue Cross fade into the pallid indifference, mottled with downright suspicion, which characterizes the public attitude toward many forms of insurance.

The whole strength of those who favor the government plan lies in whatever truth there is in Senator Murray's declaration that "a vast flood of mail beginning to pour into Washington indicates a tremendous demand throughout the country for a national system of prepaid medical and hospital care."

The senator did not say "federal system"; he did not say "government" or "compulsory." He said "national." There is nothing to indicate that a national system of nonprofit plans sponsored by state medical societies under a strong approval program guaranteeing operation in the public interest, as Blue Cross does, would not meet the demand better than it can be met in any other way.

Plainly, however, it is doubtful that many who are demanding a national system are going to hold still for an answer that includes insurance which may cost 30 or 40 or 50 cents of the premium dollar to sell and administer. A.M.A. standards do include a reference to "maximum benefits," but, naturally, a third party whose interest is in making profits will not often return as high a proportion of income in benefit payments as will a nonprofit plan whose whole reason for existence is the satisfaction of public need for prepayment protection.

Apparently, the A.M.A. believes that all sorts of insurance company plans can be tied together with the loose string of medical society sponsorship and then presented to the public as a national package. It won't work. If the doctors really want to give the public a voluntary medical insurance plan, they'd better get busy and set up some honest-to-goodness standards. If they don't, they might as well say so. Half-hearted measures which look both ways on the important principle of nonprofit public service are an invitation, not an answer, to government control.

Blue Cross Blues

THE easy way out of the problem of Blue Cross payments to hospitals is to give the subscriber a cash allowance against his hospital bill and let the hospital collect the difference between the allowance and the full bill. A few plans are doing this today in connection with certain provisions of the subscriber contract. Recently there has been a tendency to add more provisions of this nature, on the grounds that the method is fair for everybody and eliminates controversy over the amount of reimbursement paid to the hospital by the plan.

Nobody in his right mind objects to an easy solution just because it is easy. But most thoughtful people are suspicious of easy answers, because usually they aren't as easy as they look. This one is a good example. If the trend toward cash allowances continues, Blue Cross plans will ultimately become indistinguishable from other forms of insurance. They will lose a precious birthright, the community sponsorship, public service, hospital participation feature which has been their greatest strength and which rests squarely on the service benefit principle.

At the annual Blue Cross conference in Cincinnati a few weeks ago a resolution was passed reiterating the

service benefit principle and authorizing the Blue Cross commission to strengthen approval standards so that the tendency toward backsliding may be reversed. Whether this can be done successfully in the long run depends on whether a uniformly fair and practical method of reimbursing hospitals for service rendered to subscribers can be developed. This is a tough, many-sided problem, but it has to be faced and solved. In this case, the hard way out is the only way out.

You Boys Know Each Other?

IT USED to be that a man paid the doctor and hospital bills for his family out of his own pocket, and the union's pitch was to see that he had enough in his pocket. In the coal strike, which the master minds say should be settled just about the time this issue is mailed, John L. Lewis proposed a $10 a ton increase in the price of coal to finance a health and welfare program for the miners.

Now here is an ingenious idea. Carried to its logical conclusion, it offers a promising solution to the whole vexing problem of who should pay doctor and hospital bills. The idea is that everybody would pay somebody else's bills instead of his own. The coal buyer would pay the miner's bills, see? Through a tax on beer, the miner would pay the bartender's, who would pay the streetcar conductor's, who would pay the milkman's, and so on. Of course, this is pretty much the way we do it now, when you come right down to it, but nobody seems to like our way any more. This would look like a nice change and satisfy all of us.

Everybody wants to get in the act. Senator Murray, Mr. Dingell—meet Mr. Lewis.

Off-Key Note

FRIENDS of the American Red Cross are relieved to learn that arrangements for payment of fund-raising expenses to labor unions have been discontinued. Under this deal, which has been in effect for the last two or three years, expenses were paid to members of C.I.O. and A. F. of L. fund-raising committees which organized solicitation of Red Cross war fund contributions from union members. These expense payments, it is reported, amounted to hundreds of thousands of dollars a year.

In announcing termination of the payments, the national chairman of the Red Cross explained that the special, expenses-paid committees had made it possible to increase enormously labor's contributions to the cause. This may be true, although there is no good reason to pay labor union representatives for doing what all the rest of us are glad to do voluntarily. Even a larger purse from labor does not seem to justify the method, which is out of keeping with the American tradition that charitable donations are sought by volunteers.

The Red Cross does a great, compassionate work, as hospital people know better than most others. But there is something shabby about the fact that this work has had to buy support in any measure. Is there one group of Americans who will be their brother's keeper—but only if the price is right?

Hospital Day

HOSPITAL administrators, staff members and employes work around the clock and work hard. But this does not distinguish them especially. The managers and workers of railroads and utility companies and all-night lunchrooms work around the clock and work hard, too, yet no one takes particular note of their efforts.

Hospital people are efficient. They have intricate, exacting jobs requiring a high degree of special knowledge and skill—but so do civil engineers and watchmakers, for whom no public demonstrations are staged. Hospitals perform a necessary function in public life, without which the community would be severely handicapped, but the same could be said for the bus company and the newspaper, which are more likely to be condemned than commended.

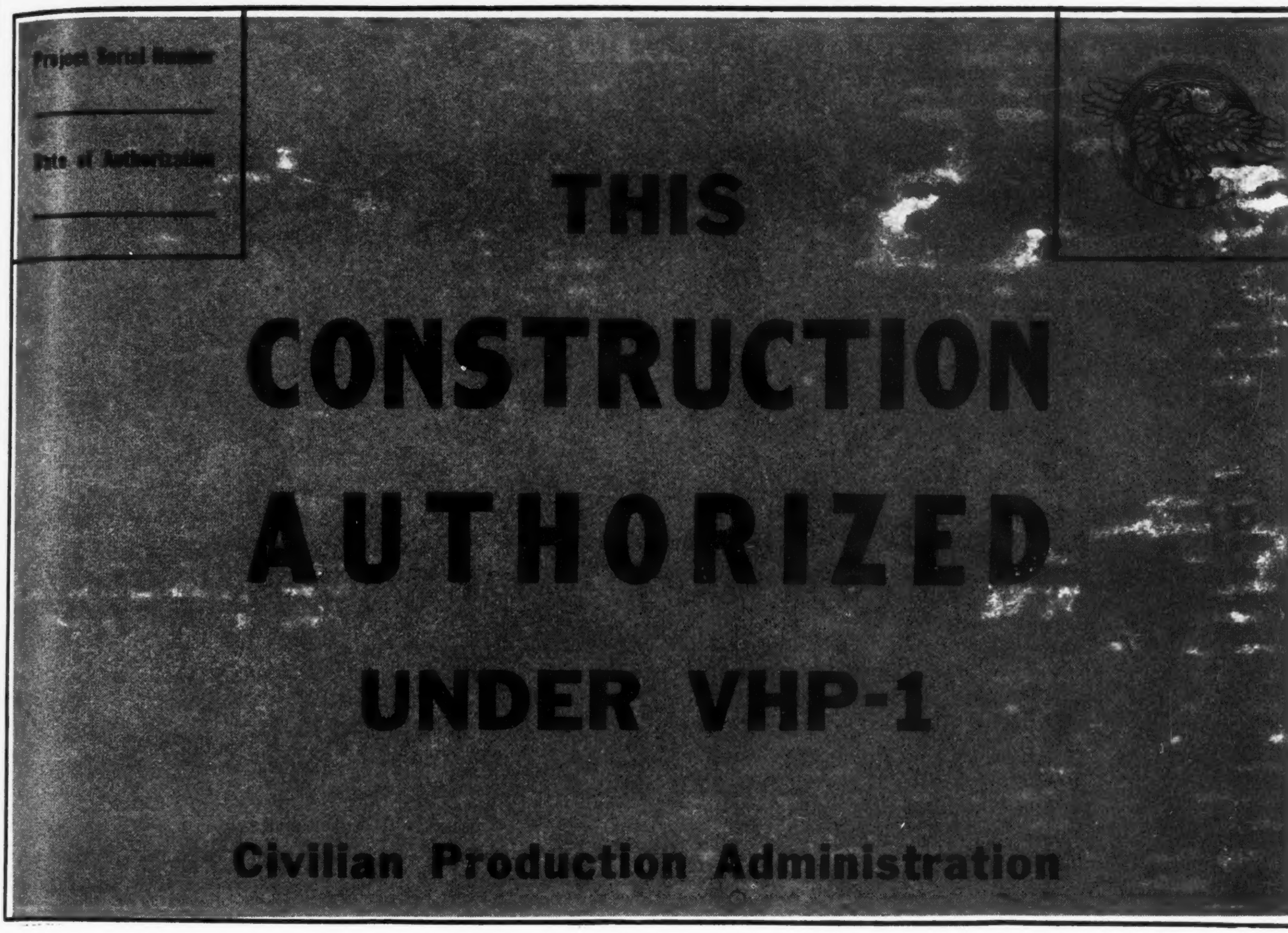
Plainly, there is something special about hospitals that commands the respect accorded them on National Hospital Day—and throughout the year. Of course, this special something is not hard to identify, though it is not easy to define. It is the hospital's intimacy with the secrets of life and death, its nearness to the quicksands of illness and the wellsprings of health. It is the nature of the hospital's work that it meets and serves people always at crises in their lives. The day's work for the doctor or nurse or hospital administrator will touch a dozen or a score of human lives, each at an emotional turning point which lends unforgettable impact to the least experience.

This is the reason hospitals are honored on National Hospital Day. This is the reason, too, that some people will always hear the name with bitterness in their hearts for remembered hurts, not necessarily the result of tragedy, but often because of some minor or imagined indifference or impatience or thoughtlessness, burned into memory at a moment when impressions are indelible. To serve at this moment of keenest need is the hospital's privilege, and its burden—a responsibility which must remain uppermost in the minds of hospital workers always.

Help Save Food!

HOSPITALS can help tremendously in the national effort to save food so that American aid can go forth in greater quantities to the hungry people of the world. Any consistent effort throughout institutions serving more than 3,000,000 meals a day is bound to produce important results. A thinner slice, a smaller order of breakfast toast—and hundreds of bushels of wheat could be freed for people who need it more than we do. Closer supervision, a little more care in the kitchen—and thousands of dollars of food waste could be prevented.

As humanitarian institutions, hospitals should be pace setters in this most desperate of humanitarian needs.



This title cut is a reproduction of the sign that is to be used on all authorized construction projects.

EVA ADAMS CROSS

WIDESPREAD misapprehension exists in the hospital and other nonhousing fields concerning the implications of the new construction control order, according to John J. Madigan, director of the Government Branch, Civilian Production Administration.

Inquiries often refer to it as a "freeze" order. Far from freezing materials, VHP-1 channels those most desperately needed into low cost houses for veterans. It was never intended to stop or squeeze out immediately essential nonhousing projects, C.P.A. insists.

John D. Small, administrator of C.P.A., himself declared recently that many nonhousing projects can, must and will be authorized; that essential and nondeferrable construction jobs will go ahead side by side with veterans' housing construction. Moreover, the director of the Office of War Mobilization and Reconversion in his sixth report to the President said: The order means a postponement of deferrable and nonessential construction but will not eliminate the construction of necessary industrial facilities, schools and hospitals.

However reassuring C.P.A.'s top officials are that the order is not aimed at hospitals or other essential nonhousing construction, hospitals will not be put in any favored class of building projects or made exempt. They will necessarily go through the screening process. They must show that their building or repair or alteration job is essential and cannot be postponed. They must convince local committees.

VHP-1 does pack a wallop aimed at all construction deemed nonessential or deferrable even if it is essential. Specifically, it forbids the beginning of construction and repair work on buildings and most other structures until authorization has been obtained. It exempts certain small jobs, not to exceed the cost of $1000 for hospitals; not to exceed $15,000 for research laboratories. For violations, it carries a punishment of fines or imprisonment.

The order forbids the *beginning* of construction even if the materials are already on the ground or if such materials are available without priority assistance. By March 26, effective date of the order, the hospital must have installed concrete footings or steel girders or foundation, brickwork or otherwise incorporated some of the materials into the structure on the site, to have made a beginning of construction. There is little chance of a hospital's slipping in some small construction job, except for the $1000 exemption, according to the *kinds of structures* the order forbids without authorization. "Structure" includes buildings, piers, arenas, stadiums and grandstands, motion picture sets and billboards, regardless of whether they are of a permanent or temporary nature. Used stands or structures which are being reerected for temporary purposes only are exempt. However, roads, sidewalks, fences, bridges, pipe lines and sewers may be constructed.

"Kinds of work" that may be undertaken are considerably restricted as defined by the regulation. Without authorization such work as: constructing, repairing, making additions or alterations, improving or converting structures or installing or relocating fixtures or mechanical equipment (heating, lighting, venti-

lating and plumbing equipment) may not be undertaken in structures which involves the putting up or the putting together of processed materials, products or equipment if these items are attached to the land; or attached to a structure and used as part of it, or attached so firmly that removal would injure the item. The laying of asphalt or other tile or linoleum cemented or otherwise attached to the structure is covered by the order.

On the other hand, no authorization is needed to do repainting, repapering, sanding floors and greasing. Repair or replacement parts in existing mechanical equipment may be repaired or installed in all types of structures when no change in the structure is made.

Although *fixtures and mechanical equipment* under the restrictions of the order may be downright discouraging, the list of those permitted is generous. Among items included in the permitted list are: machine tools, conveyors, elevators, control or testing equipment used in a laboratory, power generating or transmitting equipment, such as boilers (with certain restrictions), generators, transformers, medical equipment, washing machines or dryers, compressors or cooling equipment in refrigerators, food-warming equipment and dishwashing equipment.

However, if it is still necessary to build a hospital or do repair work or make alterations prohibited by this order unless authorized and the job is essential and cannot be deferred, apply on Form CPA-4423 to the nearest district construction office of the Civilian Production Administration. There are 70 others throughout the United States and at least one in each state. (It is understood that former W.P.B. men will be the managers of these offices.) Applications involving building projects whose costs will run over $1,000,000 will be reviewed and commented on by the district construction manager and by his advisory district construction committee and then passed on to C.P.A.'s Construction Bureau in Washington.

C.P.A. to Appoint Committees

On the formula of essentiality and deferrability will the manager of the district construction office base his approval or disapproval of the application. He will be helped in reaching his decision through the recommendation of an area review committee appointed by C.P.A. The committee will be made up of outstanding citizens in each state or community. They will be familiar with local conditions, local problems and local peculiarities. They probably appreciate the needs of the hospital and will recommend that the district manager approve the request. But if the application is turned down, appeal from the local decision may be made to Washington.

Although the hospital may be given the necessary authorization for the project, application must still be made to the Civilian Production Administration in Washington, D. C., for bottleneck assistance under PR-28 on Form CPA-541A. An authorization does not carry with it any guarantee of availability of materials. As a matter of fact, the granting of priorities for nonhousing work is expected to be sparing. The new PR-28 issued April 2 states specifically that CC ratings for nonhousing projects will not be assigned on bottleneck items listed on Schedule A of PR-33. Until this date, C.P.A. has issued preference ratings for these hard-to-get items.

In the future, CC ratings will be given to obtain these scarce materials only to complete construction necessary to the public health or safety and to complete construction required to increase the production of items designated as critical. Schedule A to PR-33, amended April 10, lists the following bottleneck items: hardwood flooring, millwork (including doors and built-in kitchen cabinets), lumber, softwood plywood, bathtubs, cast-iron radiation, cast-iron soil pipe and fittings, gypsum board, gypsum lath, structural clay tile, common and face brick, concrete blocks, prefabricated houses, prefabricated sections, clay sewer pipe and warm air furnaces.

How long will the construction order last? C.P.A. hopes that the production of building materials will so increase that the order may be either relaxed or lifted by the end of the year. But while building materials remain short, restriction will be necessary. C.P.A.'s authority is based on the Second War Powers Act to expire June 30 unless extended. The House has already voted for an extension until March 31, 1947.

CIVILIAN PRODUCTION ADMINISTRATION

Newly appointed C.P.A. regional directors and district managers who will screen construction applications in 71 cities throughout the nation are as follows:

REGION 1 (Me., Vt., R. I., N. H., Mass., Conn.): Regional Director, William P. Homans, Boston; District Managers, Charles E. Walker, Bangor; George C. Vaughn, Manchester; William P. Homans, Boston; Philip W. Simons, Springfield; James Q. Dolan, Providence; Bruce McMillan, Hartford.

REGION 2 (N. Y., N. J., Md., Pa., Del., D. C. [including Arlington and Fairfax counties in Virginia]): Regional Director, Ralph A. Parker, New York City; District Managers, W. A. Riehl, New York; J. M. Leonard, Philadelphia; J. F. Stephens, Pittsburgh; F. J. Holman, Albany; Earl R. Mason, Buffalo; John A. McNulty, Newark; Frederick Cohen, Camden; R. W. Willis, Wilmington; O. W. Carman, Baltimore; E. M. Synan, District of Columbia.

REGION 3 (Ohio, Ky., Mich., W. Va.): Regional Director, George A. Moore, Cleveland; District Managers, Glenn W. Thompson, Cleveland; Louis W. Gehring, Columbus; J. T. Grace, Cincinnati; V. H. Pfaender, Toledo; John D. McGillis, Detroit; Harry D. Rosenberg, Grand Rapids; Henry Edson, Louisville; Alex H. Cooper, Charleston.

REGION 4 (Ga., N. C., Ala., Tenn., S. C., Miss., Fla., Va.): Regional Director, John B. Reeves, Atlanta; District Managers, D. Leon Williams, Atlanta; Leonard H. Dille, Memphis; Chester O. Ensign, Greensboro; Albert H. Douglas, Columbia; Paul P. Henderson, Birmingham; A. G. McIntosh, Jackson; Charles L. Ledford, Jacksonville; P. Campbell Smith, Tampa; Clifford W. Street, Miami; O. M. McCullough, Richmond.

REGION 5 (Ill., Wis., Ind.): District Managers, W. Fred Stevens, Chicago; Albert O. Evans, Indianapolis; R. R. Valier, Milwaukee.

REGION 6 (Mo., Ia., Kan., Ark., Colo.): Regional Director, William L. Holloway, Kansas City; District Managers, Robert B. Miller, St. Louis; Sam G. Davies, Little Rock; H. O. Parsons, Des Moines; Norman J. Castellan, Denver; Acting District Manager, Alga Nothern, Topeka.

REGION 7 (Tex., Okla., La., N. M.): Regional Director, George L. Noble, Dallas; District Managers, George L. Noble, Dallas; George W. Chambers, San Antonio; Edgar G. Goforth, Houston; Walter P. Camp, Fort Worth; Merwin T. Buxton, Oklahoma City; George Pettit, New Orleans; Murray H. Sprague, Albuquerque.

REGION 8 (S. Calif., Ariz., Utah): Regional Director, Louis M. Dreves, Los Angeles; District Managers, Irving Dix, Los Angeles; John Young, San Diego; Arnold Seiler, Salt Lake City; Louis Meyers, Phoenix.

REGION 9 (N. Calif., Wash., Ore., Ida., Nev., Mont., Wyo.): Regional Director, Edwin F. Halloran, San Francisco; District Managers, Edwin F. Halloran, San Francisco; Donald W. Carswell, Seattle; Andrew J. Wahl, Boise; Edwin S. Bender, Reno; Bayard C. Wilson, Cheyenne.

REGION 10 (Minn., N. D., S. D.): Regional Director, William L. Jensen, Minneapolis; District Manager, William L. Jensen, Minneapolis; Acting District Manager, E. E. Seubert, Sioux Falls.

Washington, D. C. (San Juan, Puerto Rico): Ramon Montaner.

COME TO THE FAIR!

RAYMOND P. SLOAN

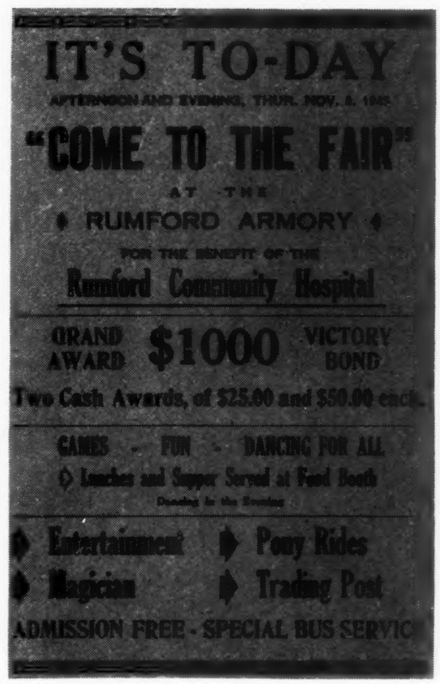
THE invitation "Come to the Fair," or its equivalent, is extended yearly to the public by hospitals all over the country. It is accepted enthusiastically and generously to the tune of thousands of dollars which help cover those ever present "extras." It is the hospital's way of making up deficits resulting from services to those who are unable to pay the full cost of hospital care, also to cover the differentiation between grants received from municipal governments and per diem costs.

Such an invitation usually bears the signature of the women's groups, which bespeaks their interest in and devotion to hospital work in their community. It is their way of rallying public support.

It May Be a Fair or a Festival

In some communities, particularly those catering to summer residents, this annual event takes place during July or August—a summer street fair in the true sense of the word. Elsewhere, it is scheduled for the fall, hence its label "harvest festival." Sometimes we find it staged in the open, its gay midway lined with all manner of attractions from Madam Sarah Abdullah, palmist, to fish ponds, all illuminated by swaying multicolored Chinese lanterns. Or we may discover it housed with greater dignity, but no less attractiveness, in an armory or other public building, or even under canvas.

Whatever their mise en scène, whatever their time or place, these fairs or bazaars are fun, plain unadulterated fun for youngsters and oldsters alike. On such days the community forgets who's who and joins hands in single jollification to the tune of pennies dropping into the hospital till. On what other occasion would you find Mrs. Cholmondeley-Cheever in perky waitress uniform passing out baked beans to the multitude, and simply loving every minute of it. And when again will you find Mr. Dunlop, president of the



hospital board, giving his all to the rôle of barker outside the magician's tent.

Yes, they are fun, these fairs, besides being highly profitable to the hospital, and they are work, plenty of work. But who minds work when it's teamwork and it is teamwork that puts these annual benefits over the top.

When we say over the top, we are talking in terms of several thousands of dollars. Profits range all the way from $1000 up to $9000 or $10,000 and they are jumping each year. The women thought they were doing well eight years ago in Wolfeboro, N. H., when they cleared $900 for the hospital. Last summer the total was $4400. In Rumford, Maine, there was considerable satisfaction in 1937 when the annual country fair produced $1600 for the Rumford Community Hospital. It looks like small change today compared with profits of $9630 reported last year. And so it goes!

At this very moment these and other communities scattered all over the country are at work on this year's plans. For one of the requisites of success is starting early. If the big day does not occur until fall, late spring or early summer will be time enough. For the summer country fairs, however, plans are already in motion.

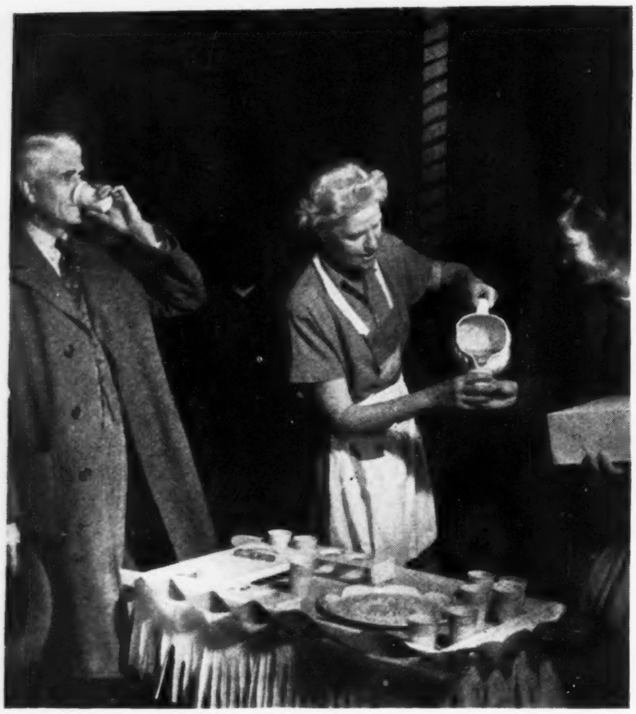
The start frequently means a tea, sponsored by the chairman, to which key women of the community are invited. In resort towns these invitations include local people as well as summer residents. Over the teacups business is discussed, chairmen are named and committees are appointed. From this point work starts in earnest, with meetings held regularly each week and oftener as the time draws near.

Here is the method of organization adopted in Pittsfield, Mass., in staging the House of Mercy's annual bazaar. This takes place in December and last year netted approximately $5000. In early autumn, according to Dr. R. J. Marcotte, director, the officers of the auxiliary group appoint two co-chairmen to organize and correlate the activities of the large group of women needed to stage the project. Committee chairmen are next selected by the co-chairmen to carry out the various activities embraced by the bazaar.

Chairmen Select Committees

A meeting of various chairmen is then held at which time general and specific plans are outlined for them to follow. Each committee chairman subsequently chooses her committee members and assigns to each her specific duties. The decoration committee is one of the first to get started because it selects the theme.

From the days of early planning until the time when the last committee chairman turns in her cash, these bazaars constitute women's effort and initiative. In this lies their success; community effort implies community strength and interest in its hospital. Consequently, it would



Left: The punch table is a popular spot at any bazaar. Below: Booths at the Rumford Community Hospital country fair, held in the state armory, offer a wide range of products: from food to flowers, novelties and toys for the children.

Photographs, courtesy Dr. Garvey Adeson

be wise to say "no" to the proposals of professional fair people who operate on a percentage basis. Better results are assured if the fair is run by its own people for its own people. The average individual is more generous when he knows that every dollar he spends goes to the hospital.

This does not necessarily imply that the men do not have a hand in things. One reason why the Wolfeboro hospital fair cleared $4400 last summer was that the municipal lighting plant furnished all the electricity and supplied men to install and remove the wiring. Too, the American Legion not only lent its tent to the ladies but put it up for them. Anything that will cut expenses helps. The scarcity of manpower has reduced such services in recent years, of course, but with the boys home again the prospects look brighter.

So among the first tasks is to enlist the support of the heads of civic organizations in town, to solicit the help of merchants in making donations of merchandise that can be sold across the counter and to gain the cooperation of local newspaper people and radio officials. It pays to advertise, always.

In Pittsfield last year, a total of 121 column inches of printing and pictures was prepared and released by the publicity committee and appeared in the single local newspaper. One merchant in town gave his fifteen minutes of radio time to the committee for the purpose of further publicizing the event. A large poster extolling the merits of a visit to the bazaar was prominently displayed in the lobby of the city's leading theater.

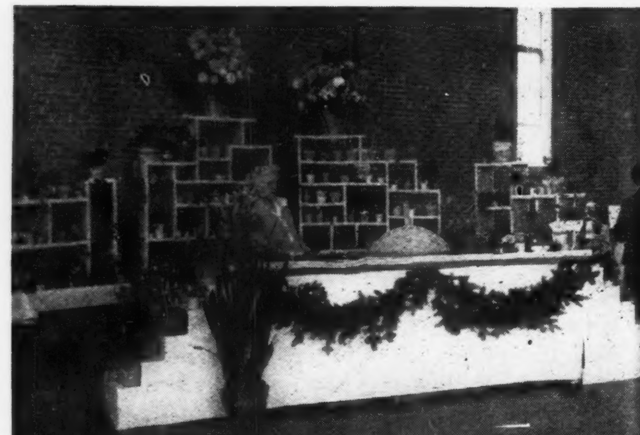
"Without these publicity mediums," says Doctor Marcotte, "it is quite doubtful if the bazaar would ever have achieved the degree of success that it did, nor would it have warranted the great amount of time and effort expended."

"What feature brings in the most money?" is one of the first questions that anyone interested in putting on a bazaar is likely to raise. This is understandable and the answer is: novelties, prizes and food.

Offer them food and they'll buy, experienced fair workers tell us. The folk who flock to these bazaars invariably bring their appetites with them, appetites for almost everything edible from ice cream cones to baked bean suppers. Rumford served lunches starting at 11 o'clock and a baked bean supper from 4:30 until 6:30. The ladies of Pittsfield served lunch and dinner meals to upwards of 400 persons at a profit of approximately $250.

They called it a refreshment center in Sellersville because not only did they serve their customers at table but provided them with food to take out. Featured dishes were homemade vegetable soup, sauerkraut and frankfurters, ice cream, chocolate milk and soft drinks.

Afternoon tea served by the ladies of Bar Harbor, Maine, during Market Day for the Mount Desert Island Hospital proved a huge success, as well as a profitable business venture. A snack luncheon was also available to those who had traveled from other sections of the island with the idea



of making a day of it. And no fair would be complete without its foods table boasting the most popular dishes, fresh from the kitchens of the best cooks in the community. The same goes for candy, although the scarcity of sugar last year handicapped the efforts of homemade candy experts.

Special attractions for the kiddies? Of course. The chances are they won't have to coax too hard either to get the older members of their families inside with them, particularly when the news gets around that a magician is actually removing white mice from the pockets of confused little boys. And this gentleman of mystery gives a special performance during the afternoon for his youthful admirers.

If there happens to be a sturdy pony or two in the neighborhood, the suggestion is to feed them up well in advance because they will be working overtime accommodating young horsemen and horsewomen who are bound to plead for just one more turn about the field—for an additional 10 cents, if you please!

There will be toy tables with their array of stuffed animals, glamorous dolls and all sorts of novelties, to say nothing of the fish pond with its delightful uncertainty of landing a package that may contain almost anything. And if you don't succeed the first time, you can always try again.

Now for the adults. A whiff of incense is sufficient to bring the ladies in droves to the space occupied by Madam Abdullah who shocks 'em nearly to death by what she reads from their moist palms. What difference if palms are not her particular medium, but tea leaves or cards! She may merely ask you to write a sentence in your best handwriting. She is mystic, nevertheless, and well worth the price. Only be sure the lady has adequate space, for she is sure to have them waiting in line.

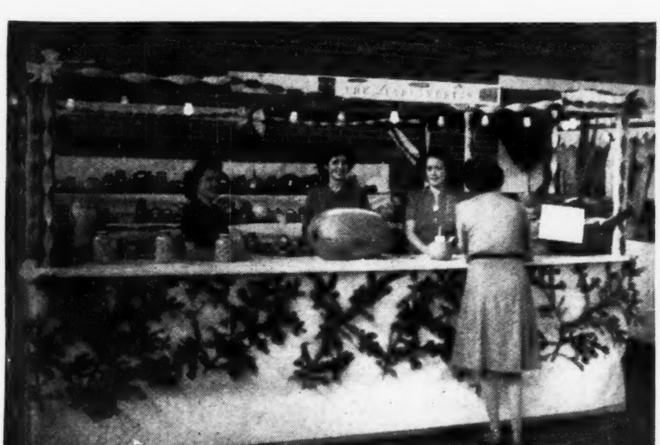
A feature of the House of Mercy bazaar was the display of wedding gowns that showed how Grandmamma looked on her wedding day.

There are card players in every group so a certain number of bridge tables will be well worth the space. Incidentally, if the canvassers have been industrious there will be plenty of good prizes from among the articles donated. Stationery received from the paper mills in Pittsfield served as bridge prizes for more than 60 tables.

After concentrating on cards, dancing will be welcome to many. The young folk have been at it for some time no doubt. It doesn't have to be a "name band" just so long as its tunes are lively and "danceable." Ten cents a dance soon runs up into figures, too.

What about a fashion show—not a regular show but a display of old-time wedding gowns? This means a search in attics and basements carried on some weeks in advance. The results probably will be worth the time and effort, however, particularly when a modest sum is charged for the privilege of beholding how Grandmamma looked on her wedding day.

While on the subject of clothes, there may be something to the idea of a fashion salon in which are displayed for sale hats, dresses and coats donated by various individuals. Ap-



Balloon, peanut and popcorn stand at the House of Mercy bazaar.

parently the summer residents of Bar Harbor found their wardrobes unnecessarily extensive last year. In consequence, there was a display of wearing apparel at the Mount Desert Market Day that would have been the envy of many a Fifth Avenue modiste.

As an extra added attraction this even boasted the presence of Mrs. Borden Harriman, former minister to Norway, who talked on war activities. Lacking a Mrs. Harriman, there may be some other celebrity in the neighborhood who will be glad to do a turn for the hospital.

Book Stall Is Profitable

Bazaars uncover all sorts of things. While searching for old gowns or unused articles that may constitute a white elephant sale, overstocked bookshelves may be discovered from which a book stall can be developed. Sales of old and new volumes were substantial at the Bar Harbor fair last year.

It simply wouldn't be a country fair without a market garden. In some communities the patrons actually wait for fair day to stock their larders with vegetables and fruits, both canned and fresh. They buy with discretion, too, knowing from which farms the merchandise comes and in which kitchens it is processed —"canny buyers," in other words.

But we might go on and on and yet not describe all the sights and attractions of these hospital fairs. Up and down the midway, ladies of the community dressed in bright gypsy costumes carry trays filled with bags of peanuts, cigarets, glasses of refreshing punch and candy. It isn't every customer who will declare himself. Sometimes he needs to be cultivated.

How these fairs grew is illustrated by the experience in Rumford, Maine. Originally its country fair was held in the Municipal Hall. So many other towns began to participate and the demand for booth space so increased that a larger hall became necessary. Because the hospital was the beneficiary, the state of Maine granted permission for the use of the armory.

Following is the net profit from these events starting with 1937:

1937—$1600.10
1938— 1673.10
1939— 2115.27
1940— 2716.12
1941— 2932.48
1942— 3423.82
1943— 4586.21
1944— 6704.66
1945— 9630.02

Incidentally, the Rumford auxiliary provided free bus service for those who had no other means of transportation.

Although for many years Nantucket, Mass., staged its "Main Street Fete" and "Wharf Carnival" each August for the benefit of the Nantucket Cottage Hospital, these have been superseded in recent years by a hospital drive. A goal figure is determined from a budget submitted in May and the entire island is divided into districts each having its own captain. The drive runs for ten days and embraces two week ends.

The day before the opening every home, hotel and rooming house receives an appeal, and prior to this special letters have been dispatched to annual contributors both on and off the island. The town is decorated for the occasion. Street banners are placed at strategic points, a thermometer is placed conspicuously in the center of the town where the temperature rise is watched with interest and the Town Crier makes frequent trips throughout the streets drawing attention to the event.

The hospital invites the public to open house with an afternoon tea on opening day. Whereas no solicitations are made at the time, new equipment and improvements are high-lighted, with members of the board serving as guides. Last year the drive committee sponsored the opening of interesting old Nantucket homes to the public, which proved a great attraction.

All Join to Make It a Success

According to Dorcas P. Clark, superintendent, this hospital drive has come to be very much a part of the island's summer activities. "From the six year oldster to the youngsters of 94 all join to make it a success. Merchants and hotel people do their part to inculcate in customer and chance visitor alike the spirit of the drive. It is the greatest public relations program one has ever seen in operation. Our goal last year was $17,000. The fund as usual was oversubscribed."

So the annual summer hospital fair or drive becomes more than a mere money-raising project. It comprises public relations, good public relations. It ties the hospital in with its community. It makes friends.

Already plans are or soon will be under way for the big day of 1946 with every indication of bigger crowds, greater enthusiasm and larger net profits than ever before. Therefore, let's say early and often, "Come to the Fair."

If I Am Ever Mentally Ill Again

perhaps the hospitals will be different

LULU WENDELL

A recovered patient cites improvements that would make the lot of mentally ill patients more bearable

Before Hospitalization

IF I had to be hospitalized again, I should like to go voluntarily or to be so committed that I should not feel like a criminal. I should not like to be treated impersonally as though I were "just another case." This "just another case" attitude still means to me, when I think of it, that I was once regarded as cheap and not worth much trouble.

This memory still frightens me at times especially when I think of the many, many people, including our veterans, who may meet a similar fate. I should like to be assured that I can and will be released as soon as possible. I should like to be told about the arrangements being made so that everything would not seem mysterious and uncertain.

I should like to be made to feel that those who take care of me, because *temporarily* I cannot take care of myself, know what they are doing and that they are doing it for my best interest. It was difficult to straighten out neglected personal matters upon release after my first illness. Therefore, I should like to know that my relatives would continue payments on insurance and other obligations or that some arrangements would be made until I could resume my responsibilities again.

I should like to be treated as a human being and given credit, even in my confusion, for being able to hear what is going on about me and to think about what is being said and done. I should like to gain confidence through the clear thinking of those around me and not to be frightened and confused more because others are bewildered too.

I should like to have every possible opportunity to get rid of my difficulties by talking them out or by writing them out for someone who understands to read and to talk to me about them. I should like to believe that all those who associate with patients and care for them get expert guidance and training for their difficult task.

Entering the Hospital

I should like to have the inside of the hospital match the beautiful grounds outside. Well do I remember how strange and repulsive the sight and sounds and smells of the hospital I first entered appeared to me. It was so terrifying compared to the home I had once loved but in which I had become sick. My very being in the hospital therefore made me more sick and more hopeless.

I should like to have a healing atmosphere similar to that of a general hospital. I should like sanitary conditions; immaculately clean bathrooms and toilets equipped with towels and toilet paper. I should like more bath days than one a week, especially in summer time. On bath days I should like to be bathed in a small group and not together with 40 or even a hundred other patients. A bath or shower can be soothing and pleasant but not in a huge crowd of excitable people.

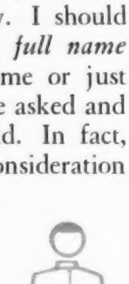
I should like to be sure to have a towel to dry myself and to have my clothes nicely given out, not tied up in a bundle and thrown at me. In winter I should like to be allowed to have my sweater and coat, especially after the bath. I can remember that even old patients were sent outside right after the shower. Their hair was still wet and hanging around in strings until someone, patient or attendant, came along and fixed their hair. These patients were shivering in the cold. No wonder bath day was disliked and dreaded!

I should like to be able to keep neat in appearance and not to have my hair combed with the same comb used for all patients on the ward. It would be nice to be able to have one's hair "done" and not to have it cut short just because it is the easiest way to keep it neat when one doesn't have a comb.

I should like cleanliness, simplicity, order and cheerfulness in the rooms and day halls, with color, flowers, pictures and other objects pleasant

to look at. I know that some patients *may* destroy some of these things in their desperation. But many simple colorful objects *can* be added which brighten the rooms. I can almost believe that patients would not get so stirred up if the hospital looked cheerful and hopeful.

I should like to be in rooms together with patients whose suffering is much like mine, not with patients who are sicker and whose actions are frightening. I do not want to be treated like an animal. Most of all I should like to be welcomed and to be treated respectfully. I should like to be called by my ***full name*** and not by my first name or just "you." I should like to be asked and not to be ordered around. In fact, courtesy and dignified consideration would go a long way, I am certain, in building up my faith in life and in myself again.



I should expect to have a prompt interview with the doctor who would take care of me. I should appreciate a talk with the head nurse or the attendant so that if anything goes wrong there would be someone to whom to turn. My being "passed around" to a number of people and having to tell my story again and again kept very much alive my sense of being wronged.

Perhaps I should be hesitant and unable to describe my difficulties but this should not bring about a situation in which nobody bothers about me. I should not want to be considered hopeless, unable ever to "snap out of it." Even if this were probable, I should have a better chance if it were not said in my hearing.

I should like to have the course of treatment explained so that when tied up helpless in wet packs or put into a continuous bath I should not worry. I should like to have someone explain why I am stripped of my clothes and few personal belongings and forced to dress in clothes just like the other patients. Is this really necessary? When I was without any identification, I was convinced that I had forever taken leave of myself.

Perhaps if I am ever mentally ill again, the hospitals will be different so that I can have a few personal possessions to keep me in touch with

happier days. It was next to impossible to live for years without a pocket, pocketbook, handkerchief, toilet paper, writing paper and pencil, money. It was terrible to have to wait until someone ***chose*** to let me have access to my things. It brought about the reaction that I did not want anything anymore because the fuss about it was too annoying.

It was a great improvement to be allowed a pasteboard box under the bed when I was promoted to the "best" ward. I should not ever want to live "in a box" again, though. There might be a space-saving way of providing each patient with a combination chair and drawer next to the bed. Surely, someone could design a chair of this type and it could even be made by patients in the hospital's carpenter shop. At least such a chair and space could be the patient's own and a link with the past.

I remember how lost I felt without my wrist watch and how time went on so slowly and became so uncertain when the hospital clocks stopped and I did not see a calendar. In my uncertain state of mind it made me lose track of the date and I began to doubt the reality of magazines and papers on the tables. Many of them were old; especially were the books outmoded. Something ***new*** to read would instill confidence and hope and would remind me of pleasant things and help me to get better.

A little pamphlet about the hospital similar to those one receives when one goes to school or summer resorts would be helpful. Even a small schedule in the rooms and halls, telling about the general course of the day and hospital rules, would be helpful in acquainting me with my new surroundings.

I should hope that I would be well enough soon to welcome a hospital newspaper. (See *Mental Hygiene*, October 1942, p. 610, "Mental Hospital Newspapers" by Nathan Blackman, M.D.) This would tell of the various activities of the patients, of treatments, occupational therapy and recreation facilities available. Perhaps I could look forward to working on this paper later on. I might learn from this written material the rules about visits, when they are permitted and why at times patients have to wait till they can see their relatives.

I might also be helped by the bulletins of the W.A.N.A. Society (We Are Not Alone), an organization of recovered patients which was formed in 1944 in New York (mailing address: Box 61, Station K) with a great potential in rehabilitation and public education. Books and magazines "like home" would help. They would give me something beside my troubles to think and talk about.

During Hospitalization

I should hope to receive prompt attention so that I should not have to wait several weeks on the receiving ward for transfer to a treatment ward. When transfer becomes necessary or advisable, because either my condition has improved or a different course of treatment has been decided upon, I should like to have the reason for the transfer explained to me *beforehand*. I would then know why I am going to another ward and could help myself get better faster because I have some understanding.

I should like to have my clothes and few personal belongings transferred along with me in a respectful manner and not thrown into a pillowcase and transferred days afterward. It is terrible to feel adrift with nothing familiar to indicate that one is truly a human being.

I particularly recall the transfer from one hospital to another owing to overcrowded conditions. So that patients could be identified in the rush of transferring about 250 patients, we had our names written on a piece of adhesive tape and stuck on our backs. When I lost this tape a few days after the transfer, I felt that I had lost my identity. I had no proof left who I was.

There are still hospitals that have only attendants on the wards. I should hope that my hospital could have registered nurses and that their skill and understanding would be such as to give me courage to do my share toward getting well. I should like to feel that all efforts are being made to return me soon to the outside or, if the stay should

have to be long, that it will be made as pleasant and healing as possible.

I should like to know whether I am a charity patient or whether someone pays for my hospitalization. It might make me feel better to know that someone cares enough to invest in me. Again, the fact that the state is caring for me might make me feel less of a burden to my loved ones. Certainly, it would be better than ignorance even if the actual truth might trouble me at first.

I should hope not to be restrained at all unless it were absolutely necessary. When I was ill, restraint, or at least the way it was imposed, increased my fears and insecurity greatly. Although restraints might outwardly calm me, I am certain they would again bring on further depression as they rob a patient of the little freedom he still has. They did fill me with despair, resentment and revenge rather than with hope and confidence. I learned to keep still to avoid further trouble but my silence did not mean that I was getting better.

Nor would I want to *see* others harshly restrained because the sight of their helpless condition would be utterly depressing and frightening to me. I should not ever want to be tube-fed again. As I remember it, this was a painful and unsatisfactory way of receiving nourishment. Rather would I hope to have special and attractively served food. At least a tidy table or tray would help my appetite.

If attractive plates are not possible in quantity cooking and serving, my relatives could help with little surprise packages containing candy and bits of special food. Or they could provide a small allowance for spending money so that I might order some groceries and necessities through the attendant or nurse in charge.

Surely, something of this sort could be arranged to make the hospital for the mentally ill more like other hospitals.

Although in the hospital one is surrounded by many people all the time, it is next to impossible to overcome the depressing feeling of aloneness if for a year or longer one has no sign from the outside. Therefore, even if, for a while, I should have the reaction of pushing everything away from me and shutting myself off, I should not want to be left stranded, forgotten and "buried alive." I should like to have contact with the outside world through letters, notes and visits. If they mean little at first, they will mean more as time goes on. I should hope that my incoming and outgoing mail would be handled carefully and promptly. The mere fact that letters are received or that people come would help. I should like the visitors to tell me news even if I made no response.

I should like to be able to expect prompt physical and mental treatment used *together* in an interplay for the quickest restoration of my health. There seems to be a tendency in some hospitals to give physical treatment without psychotherapy. Even when I was most frightened, proposals made slowly and distinctly, one or two at a time, could have been grasped. Unfortunately, people talked to me rapidly and ordered me about, often pushing me, which I resented. Therefore they called me "uncooperative" and "resistive."

I should like to have confidence in the people whom I see every day and who are an example for me of "normal" people: the attendants and nurses. They are the ones who are most likely to be around whenever I need reassurance and my mind put at ease. Those around me would have a great deal to do with convincing me that the treatment is beneficial. Unless I am led to get at the root of my problems, quick and permanent healing will not be possible.

Regular interviews with the doctor, nurse or attendant and social worker would interrupt my dreams and fantasies and bring me back to reality for a while until I become well enough to face life again. During these interviews I might learn that a complete record of my case is being kept and used as reference. To tell my story repeatedly always gave me the feeling that nobody cared enough about me to remember what I had said. This made me weary and discouraged while I was ill. A record would give the patient a sense of order, care and discipline.

I should hope to find the doctor and the attendants always friendly. I should like to be treated respectfully and cordially by them rather than in a condescending or derisive manner. *This happened to me; I have seen it happen to others.* I so well remember the probably well-meant, joking approach of my doctor one time: "Let me shake your paw."

Under ordinary circumstances my sense of humor would have created a friendly reaction within me. As it was, throughout nearly two years, I had seen patients locked up in "dog

houses" and had seen them treated worse than dogs. This made me extremely sensitive and the use of the word "paw" implied that I, too, was no better than a dog.

Talking with the psychiatrist and others, I should like to be informed about the terms relating to my mental illness. It would eliminate a great deal of fear and mysteriousness which most of us still attach to "insanity."

Then, when I am well enough, I should like to be knowing the different classifications and their particular symptoms. This would help me to understand my illness just as we like to have a physician tell us what it means when we have bronchitis, pleurisy or pneumonia.

I should like to have as much personal freedom as possible and not to be locked between or outside or inside doors. To a sensitive ear the rattling of keys by attendants who are locking and unlocking doors becomes extremely annoying. To be confined behind doors is an overwhelmingly depressing experience even for emotionally stable persons. It is all the more so for those who are easily depressed.

I am sure that gradually I would gain interest in some diversion. Perhaps at the very first I should like a few days of absolute rest but I should not want to be sitting, waiting and thinking for weeks. At first I might just want to listen to music or to read slowly and quietly. Later on I would want and need to participate in the hospital activities, in some of the ward work, games, physical exercise and musical entertainment. I should know for sure that, even though weak and temporarily incapable, I still can learn new things and absorb new thoughts which would take the place of some of my negative thinking.

Just any work, as, for instance, hours and hours of polishing floors, would not do. Work to be helpful must be something useful, something that I like to do or that might be a preparation for my return to my family. I well remember how utterly useless it seemed when I had to restring a large loom. It took hours of tedius work which *I knew* meant nothing for the future. The many tangled and broken threads took on symbolic meaning telling me that the threads of my life were as tangled and broken as those of the loom.

I remember that regular work in an immaculately clean and orderly sewing room greatly helped to restore my self-confidence even though it was monotonous at times. The change from hopeless idleness to an attractive useful setting helped *me*. Other patients I knew were usefully occupied in laundry, kitchen, ward, canning or art work. They all probably preferred activity of any kind to the dull monotony of ward life. The work could have helped more, I am sure, had it been varied and administered less like slave-driving.

I often longed to do garden work, to care for flowers and plants. Such occupation might have had great value in healing a case like mine although someone else who dislikes gardening might find it discouraging and offensive. I know of patients who have been kept at the same monotonous job for years because they originally *made the mistake* of doing it well. While the work of the supervisor thus is made easier, the activity does not contribute as much as it should do to a speedy recovery.

In our sewing room not only were we rewarded for our work by atten-

tion from patient and kind attendants but the tasks were pleasantly interrupted by little morning lunches and an occasional treat of pie or cake in the afternoon. We also received the monthly payment of 50 cents. While this small amount was in recognition of our work and was generally appreciated by the patients, to me it seemed almost like an insult. I knew that my services were worth far more than 50 cents a month. If in the future the work of patients within the hospital can be recognized, I should hope that the remuneration may approach to some extent the amount paid on the outside for equivalent work.

Before Discharge

I should like to feel that close cooperation exists among the doctor, nurse or attendant and social worker. It would be undermining the patient's confidence if, for instance, the doctor told the patient that she should go to work in the art room for occupational therapy and the attendant sends her to the laundry. It is particularly bad when the attendant is harsh if the patient protests. This happens.

A fine example of cooperation between doctor and attendant marks the case where the attendant recognized the recovery of the patient while the doctor still had doubts about the patient's ability to face the outside world. The attendant greatly helped the patient and ultimately the patient's family and the state by suggesting that the patient's full recovery be tested within the hospital through strenuous work which was entirely different from the work she had been placed in for two years in the hospital.

Within a few days it was obvious to the doctor, too, that the patient was entirely well and she was soon released. Had the attendant been disinterested or less understanding, the final recovery of the patient and her discharge would have been delayed.

If I were on my way to recovery, I should like guidance for future work and rehabilitation on the outside. It might perhaps be beneficial to go through an intermediary period of working on the outside with the opportunity of returning each evening to the familiar surroundings of the hospital.

Experiments with "working-out" programs have been made. (See *Mental Hygiene,* July 1945, p. 429, "A Working-Out Program for State Hospital Patients" by Jean Campbell.) Under the stresses and strains of ordinary normal living and employment, such improvement has been brought about by this gradual "induction" that the whole philosophy of occupational therapy may well be changed some day. Family care and other programs of employment have also aided recoveries.

I should like to have the social worker assist me in my problem of rehabilitation. She might help me to catch up on what has happened to my family. She perhaps could explain things that I thought had happened which I did not understand. Perhaps she could give me direction for future work. She could also refer me to a guidance clinic or state society or a psychiatrist with whom I could have contact whenever I feel the need of it.

It would be of great value, too, if she could prepare the members of my immediate family for my return and convalescence just before I come home. They might otherwise feel ill at ease about how they should treat me. Their insecurity, in turn, might make me afraid again.

Even after full recovery, new adjustments are necessary. It would be very difficult to be released from strict supervision and suddenly be without a guide or guidance. It would perhaps bring back some of the old fears. The social worker might acquaint the family members with my fundamental problems of readjustment and direct them to the same sources of guidance as mine. We might even *go together* for advice.

When I am ready for new interests in the outside world, it would be of great help to read about mental health and related subjects. It was wonderful to learn about the mental hygiene movement after my own illness but it has amazed me to find out how much is known and

done in a few places on the outside, how much understanding exists in certain places, yet so little of it reaches the patients in hospitals.

I should hope that the example of Clifford Whittingham Beers, founder of the mental hygiene movement and the National Committee for Mental Hygiene, will not soon be forgotten. I hope that in the future recovered patients and all those who understand the meaning of mental health will create and maintain widespread interest and good will toward this vital problem. The public must be encouraged to face mental illness as it has come to face physical illness.

Therapeutic Value of Religion

It was my experience that religion is more healing than any other treatment. Healing is accomplished through faith, hope and love. Religion that is based on these qualities, therefore, can be more healing for a broken mind than are physical surroundings and scientific treatments. This is true for many patients.

Throughout all my confused thinking one sentence remained as a source of comfort: "Life is spiritual." Gradually, I was able to add to this a list of fundamental values and needs. If I were again in such a process of integration, I think that I should greatly appreciate the assistance of a religious worker or minister. If I had not established full confidence in either doctor or attendant, I might have it in trained religious workers who would be the link between the hospital and the outside world. (See "Religion and Health" by Seward Hiltner.)

While I might hesitate to talk myself out with my doctor, I might be able to do this with a religious worker, reasoning that if he does not condemn me, I am not as bad as I thought I was. This could lead to a more positive attitude toward hospitalization, doctor and family. Participation in worship services, collective prayers and responsive readings might be a source of inspiration and comfort. It could give the feeling that I am not alone and would bring a socializing effect toward community adjustment. (See The MODERN HOSPITAL, July 1945, "A Chaplain Is Needed in the Psychiatric Hospital" by Rev. Ernest E. Bruder.)

Others feel much the same as I about this. Recently I learned that work of this kind is done at an eastern state hospital through the untiring efforts of a recovered patient. A chapel was made available for the hospital. There, patients, visitors and neighbors have regular inspirational meetings. A society and committee have been found to work with the patients so that they may gain insight and will be led to a quicker and fuller recovery.

In planning improved treatment, hospitals of the future might encourage religious ministry. Not only would the patients with religious attitudes be benefited by individual and group counseling but the members of the staff of doctors, attendants and others might be fortified through daily hours of worship. It might be of great help to them in fulfilling their difficult service toward recovery and well-being of those entrusted to them.

Dr. Charles W. Page once said: "What the insane most need is a friend." To be a friend would not need great expenditures or large detailed programs. All it does need is the knowledge of the Golden Rule, lots of understanding and the capacity to love.

I cannot think of a better way to conclude this essay than to quote from a message from Dr. Karl A. Menninger*:

"If we can love: this is the touchstone. This is the key to all the therapeutic program of the modern psychiatric hospital; it dominates the behavior of its staff from director down to gardener. To our patient who cannot love, we must say by our actions that we *do* love him. 'You can be angry here if you must be; we know you have had cause. We know you have been wronged. We know, too, that your anger will arouse *our* anger and that you will be wronged again and disappointed again and rejected again and driven mad once more. But we are not angry—and you won't be, either, after a while. We are your friends; those about you are all friends; you can relax your defenses and your tensions. As you—and we—come to understand your life better, the warmth of love will begin to replace your present anguish—and you will find yourself getting well.' "

*Bulletin of the Menninger Clinic **8**:105 (July) 1944.

Administrative Capsules

E. M. BLUESTONE, M.D.

Director, Montefiore Hospital, New York City

• DON'T BE A HOSPITAL ADMINISTRATOR, be "the gentleman who runs the hospital."

• ONE OF THE GREATEST ACHIEVEMENTS of medical social service in our time is the reduction of relapses of illness through careful and conscientious social planning.

• PLEASE REMEMBER THIS: that a "chronic" patient can be acutely ill for long periods of time.

• WHEN THE MEDICAL SOCIAL WORKER is left holding the bag because the visiting staff has lost interest in a patient, she must uphold the right of such a patient to continued care as long as he needs it. Otherwise, she becomes an accomplice in a procedure which denies to the patient the scientific care that he needs at a time when he needs it most.

• WE WANT THE VOLUNTEER in hospitals who reacts instinctively to the needs of the sick.

• THE ABILITY to give more than a guarded prognosis during illness involves the gift of prophecy and very few physicians can claim this gift to the extent that they can separate out the incurable from the curable and plan separately for each.

• FOR THE HOPITAL PATIENT freedom from fear is the most important of the Four Freedoms.

• NO INSTITUTION has ever been created which is better qualified to deal with the problems of long-term medicine than the modern hospital.

Two Beds Add Up to Many Problems

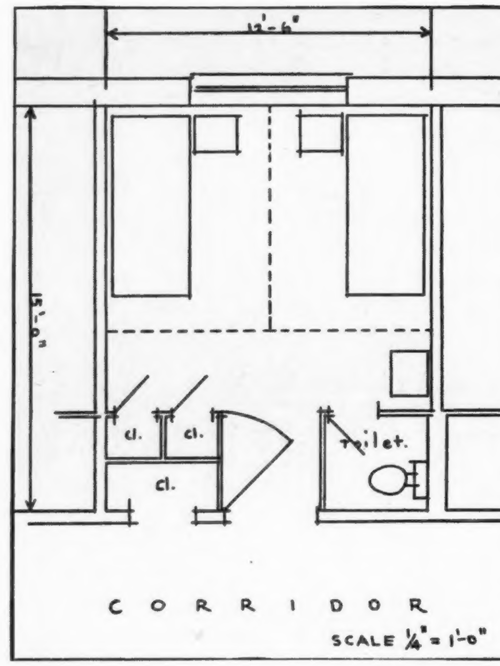
FOR ARCHITECT AND ADMINISTRATOR

THERE IS A PUBLIC DEMAND, INTENSIFIED BY THE BLUE Cross contracts, for double rooms. Is a good double room possible? My experience is that one patient is near the window and the other is unhappy. When patients accept four or five bed accommodations, they accept the fact that they will not have the privacy of a single room, but with doubles the inconveniences become accentuated. "Why should I be in this bed? I like the air, she doesn't! etc."

Then there is the problem of corridors. Is there a hospital in which corridors are not also working space? I should like to study a hospital plan in which the corridors are used by doctors, visitors and personnel going on and off duty, only to go from place to place.

In most hospitals, the utility room, treatment room, flower room, janitors' closet, diet kitchen, linen closet and other service facilities make cross traffic back and forth across corridors essential. This adds to noise and confusion and invites "hall conferences."

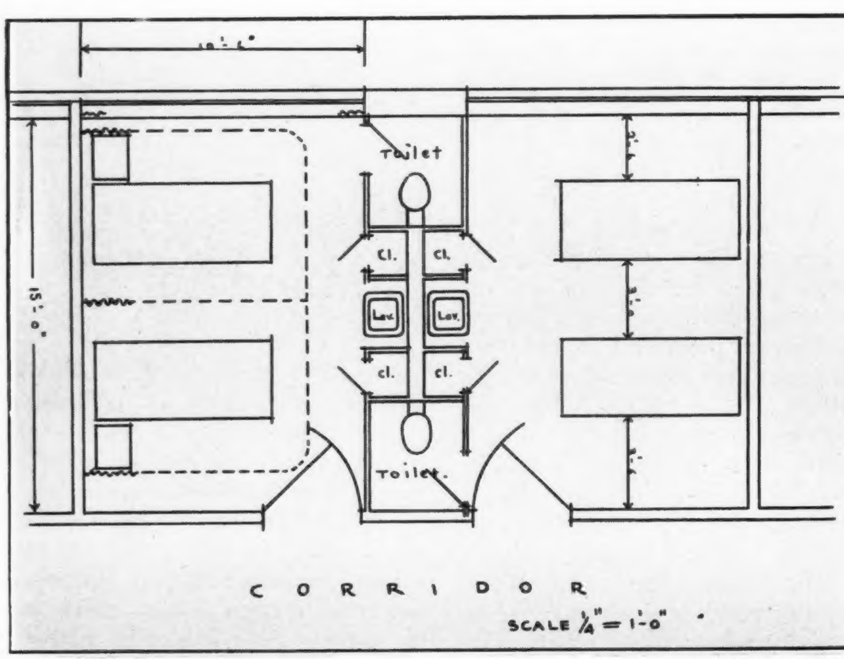
When you find a plan that remedies these points let me know! — NELLIE G. BROWN, *superintendent, Ball Memorial Hospital, Muncie, Ind.*



SCHEME A

ALAN FISHER
Architect
Fisher and Fisher
Denver

WE ARE interested in the problem of the two bed room. Accordingly, Arthur Fisher studied the problem of handling the two bed room so that each bed becomes the equal of the other from a location point of view. The accompanying sketch (A) is the best solution that was uncovered. Another solution (B) is also included, which seems to be the more standardized layout in present day hospital design, where water closets are provided for each two bed room. We wish to comment on qualities relative to each of these schemes as follows:



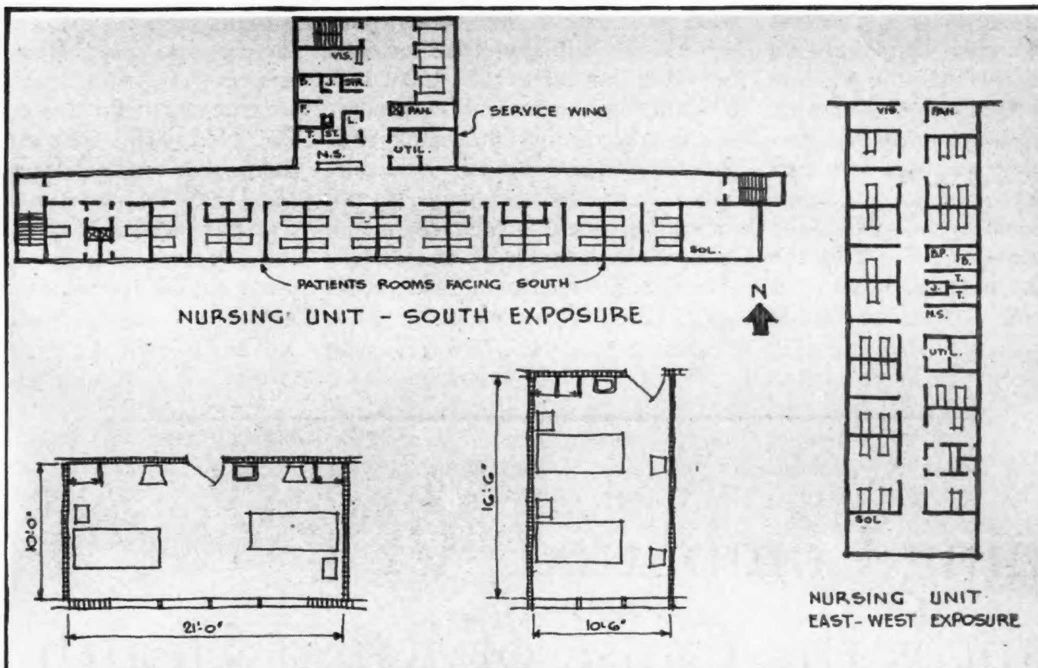
SCHEME B

1. The areas of schemes A and B are identical: 187.5 square feet.

2. Scheme A requires the moving of the bed out from the wall during the examination of the patient or the servicing of the bed. Such moving might be detrimental to the comfort and well-being of certain patients and also makes fracture frames and other items of treatment equipment, such as oxygen tanks and intravenous equipment, difficult to place and handle; it also disorganizes the room arrangement.

3. Scheme A limits the window width to the distance between beds. We feel that the full room window opening, equipped with manually drawn, washable curtains, is superior to the usual "hole punched in the wall" window for patients' rooms. The latter type of window almost requires the use of venetian blinds or a most domestic treatment of draperies and window shades. These are less sanitary and produce a greater maintenance problem, whereas the continuous curtain (and color may be used) is no greater a problem than is the laundering of bed sheets. Perhaps this curtain should be changed with the change of patients.

4. Scheme A provides a closet in the corridor at each two bed unit.



A TWO BED ROOM WITH BOTH BEDS ADJACENT TO THE WINDOWS WOULD RESULT IN A MUCH LONGER NURSING UNIT, GREATER EXPENSE AND MORE DIFFICULT NURSING BECAUSE OF INCREASED WALKING.

Such an inclusion might be convenient in operation for the broader distribution of linens throughout the hospital and might also be a means of discouraging linen room raiding by special nurses if linen were rationed to each two bed unit directly by the central hospital linen department. On the other hand, the inclusion of such closets might be considered as purely wasted space.

5. Scheme A almost precludes the ability of the patient to look out the window. We feel that such a condition is seriously detrimental as the patient's vision is limited to a static view of doors, walls and ceiling, whereas with window views an active sight is always present.

6. Scheme B provides a better organized plumbing system.

The patient cannot face the light. Double deck beds will hardly do. Economy of space must be considered. All in all, the problem of equality of location of two beds in one room offers a challenge. We are in sympathy with Miss Brown's problem and see the focal point of much patient complaint.

In regard to the corridor problem, we feel that economy of space requires that the corridors act to some extent as "working space." This is one reason for greater corridor width in hospitals than in any other type of building. The matter of "hall conferences" becomes an administrative problem.

MARSHALL SHAFFER

Chief Architect
Hospital Facilities Section
U. S. Public Health Service

WITH regard to the question on double rooms, the desired objective could be accomplished by making the room some 9 to 12 feet wide, thus having the unit one bed deep. When the room takes two beds, it would be 20 feet wide with the extra bed facing the existing bed. However, this arrangement calls for a lengthened nursing wing and it is also costly because of the greater perimeter.

The problem of service rooms being off the corridor can be answered by placing them in the middle of a T and having the beds on the top side of the T, with beds on only one side of the corridors. This, again, is a little more costly and also requires more steps for the nurse but would to no small extent keep the main traffic concentrated in one area away from the majority of the patients' bedrooms.

WILLIAM A. RILEY

Architect
Curtin and Riley
Boston

TWO bed rooms (semiprivate) can be designed so that each patient's bed will be parallel with the corridor and each bed will have the advantage of an outside window.

This arrangement would contain the same floor area per bed that is required in good hospital practice. However, the width of the building would be smaller and the patients' pavilion would be longer. By a little architectural ingenuity, a plan could be worked out, such as increasing story heights and decreasing the size of nursing units. With this arrangement, the two bed room would always be a semiprivate room and not a private room designed to accommodate two beds in an emergency.

In regard to the question of corridors, it is possible to have corridors that are not used as working space. We plan our hospitals so that service rooms are concentrated away from patients' rooms. In this arrangement, patients are on only one side of the corridor, which has excellent features. This idea is not new; it existed in Europe long ago.

CARL A. ERIKSON

Architect
Schmidt Garden and Erikson
Chicago

THE difficulties referred to about the two bed room are inherent in that kind of unit. Some administrators take the position that there should be no two bed rooms but only private rooms or the next stage, the

four bed unit. Apparently, personality clashes in a two bed room are even more difficult than the window problem. Yet there are other hospital administrators who brush all this aside and think that the two bed room has many virtues.

There is one way of solving the problem, but it is jumping from the frying pan into the fire. It is to put the head of the bed at the outside wall, probably in the corner, and provide two windows (one for each bed), but that leaves the patient in a bad nursing position and with nothing to look at but the blank wall opposite and no view of the outside.

We have obviated some of the difficulties about corridors in a few hospitals by introducing a secondary corridor on which all service rooms open. It is a scheme which we think is highly desirable. We suggest that the elevators be so arranged that all services (everything except visitors) are discharged on this service corridor. Necessarily, the corridors of the rooms must be used for some traffic, and I don't suppose there is any more chance of stopping conversations in the corridors than there is in stopping similar conversations in the middle of State and Madison streets!

Planning Committee Advances the Cause of Rural Health

H. C. FILLEY
Chairman, Department of Rural Economics University of Nebraska, Lincoln, Neb.

DURING the last twenty years the enrollment in the women's home demonstration clubs sponsored by the Nebraska Agricultural Extension Service has varied between 20,000 and 30,000 members. The projects undertaken have included a great variety of subjects, from making hats to cooking dinner for a threshing crew, with side excursions to such topics as the best books to buy for growing children and the duty of a good citizen to vote at every primary election.

During the 1930's requests for a project on rural health became insistent. Thousands of farms are located many miles from the nearest physician. The women wished information upon such subjects as "what to do until the doctor comes," "what things can be done so that it will not be necessary for the doctor to come" and what can rural people do to assure medical attendance and hospital care.

Health Project Started

In response to these requests a project entitled "Medical Care and Health of Rural People" was undertaken by the University of Nebraska College of Agriculture in July 1939, with financial assistance from the Farm Foundation. A committee of four from the university staff was set up to supervise the project. The objectives of the project were stated as follows:

1. To stimulate rural people to study the health facilities available to them and to consider ways by which more satisfactory health services can be provided.
2. To encourage families and groups of families to plan for better use of available health resources and to develop additional facilities needed for adequate health care.
3. To develop, with the cooperation of physicians, dentists, hospitals and other health agencies, ways and means by which many of the difficulties responsible for inadequate medical care of rural people can be overcome.
4. To serve as a guide for projects in other areas.

Work on the project was initiated in Dawson County because of the interest in health shown by the rural people in that area. As interest in the project broadened, a circular, "Do We Want Health?" was prepared for study in the 1700 home demonstration clubs in the state. Other organizations later made use of this pamphlet for study. Round table conferences were held in many counties to analyze health and medical needs.

By August 1941, sufficient progress had been made so that the College of Agriculture and the Farm Foundation sponsored a state round table conference on "The Medical Care and Health of Rural People." One of the results of this conference and of the requests made by rural women was the setting up of the Nebraska Health Planning Committee.

Various Agencies Represented

The members of the original committee included the four members of the agricultural college committee, a health specialist employed by the Farm Foundation, two physicians, one dentist, the secretary of the state medical association, two representatives of the home demonstration clubs and representatives from the Farm Bureau Federation, the State Grange and the Farmers' Educational and Cooperative Union.

One of the first acts of the committee was to invite the director of the state department of health and the director of the bureau of assist-

ance to join the group or to delegate members of their staffs to attend. These agencies have been most helpful.

The number of members of the committee and the number of organizations represented have gradually increased. Most of the organizations that have a direct interest in rural health are supporting the committee and its program. The attendance at the monthly meetings of the committee has been unusually good considering that every member is a busy person and that some of the members live more than 150 miles from Lincoln.

Rural Problems Studied

The purpose of the committee, as set up at its first meeting in September 1941, was to study the problems of medical care for rural people, propose plans and make recommendations for carrying out the plans proposed. Work was to be confined largely to the study of the Nebraska situation and the health plans worked out in other areas and to educational activities. Action programs were to be the responsibility of local communities. As the work of the committee progressed, the scope of the program was broadened to long-range planning for a health and medical program for the state.

In October 1941, the committee discussed the problems involved in providing a satisfactory medical program for sparsely settled areas, such as the Nebraska Sand Hills. In December, Graham Davis of the W. K. Kellogg Foundation, Battle Creek, Mich., came to Nebraska to meet with the committee and with people in Thomas and Blaine counties who were interested in health problems. Neither of these counties had a physician, and as a result the residents had difficulty in obtaining medical and hospital service.

As a result of Mr. Davis' visit and of some additional work done by members of the committee, the Sandhills Health Association was organized in June 1942. The state medical association aided in obtaining a physician and the state health department assisted in obtaining a public health nurse to work in the area. Many families paid a fee for membership in the association and funds were appropriated by county boards. The physician was assured a fairly satisfactory income and an opportunity to inaugurate a new type of medical service. The community was enthusiastic over the project.

Within a year an old hotel building in Thedford was purchased and remodeled to provide an office, an operating room, two wards and rooms for a caretaker, and the residents of the two counties and a part of two adjoining counties were enjoying as good medical service as that provided in many more densely populated areas.

The organization of the medical program in these two counties convinced the committee that legislation was needed to promote the establishment of county health departments. The League of Women Voters took the lead in writing the bill and presenting it to members of the legislature. The bill as passed gives additional powers and responsibilities to the state department of health and provides that a county with more than 60,000 population may set up its own health department, and that counties with less than 60,000 population may combine with other counties to form a district health department.

It is anticipated that many counties will organize a health unit, combine the health services that are now offered by the county board and the various towns and cities within the county and establish a fairly comprehensive county health program.

Surgical Care Plan Offered

In October 1944, the Nebraska Medical Association offered its group surgical plan to the people of the state. In formulating this plan the association was undoubtedly influenced by the requests made by the men and women in attendance at the first health conference.

In April 1945, the Nebraska Farm Bureau Federation set up its plan of hospital and surgical service for farm bureau members. This plan was apparently the outgrowth of the sentiment favoring health care that has been generated since the formation of the Nebraska Health Planning Committee.

It would be easy to mention a fairly long list of health activities that have been aided by the health planning committee. Part of the contributions have been direct, *i.e.* the assistance in organizing the Sandhills Health Association, and part has been indirect, such as the increase in appropriations for the state department of health. Probably the appropriations would have been increased even if the health planning committee had never been organized, but the publicity given the committee and the interest of the home demonstration clubs in its work undoubtedly helped to arouse general interest to the need of giving greater attention to a public health program.

The health planning committee does a part of its work through four subcommittees on: (1) prepayment plans for medical care, (2) hospital services, (3) public health and (4) education.

Some of the activities of the committee on prepayment plans have been mentioned previously in this report. Members of the committee have given information concerning the Blue Cross plan and have thus aided in arousing interest in this worth-while program.

The committee on hospital service has assembled some information on hospitals but has not had funds available to make a survey of Nebraska hospitals.

Must Cover Broad Field

The committee on public health has a broad field to cover. One of its tasks is collecting information on the public health plans in use in other states and Canada and their adaptation to Nebraska conditions. Another task is studying the health situation in Nebraska communities.

The committee on education has one of the jobs that never ends. There is always new information to be given out and new generations to be taught old truths. The committee must decide which methods of presentation shall be used and to what extent they can be used. Present plans include the holding of several district conferences on health and medical care.

The Nebraska Health Planning Committee will help other health agencies through research and teaching. Members of home demonstration clubs, agricultural extension specialists, leaders of farm organizations and other public-spirited men and women will work with the state department of health, state and county medical societies and other men and women in arousing an interest in the possibility of reducing disease and obtaining better health conditions.

The V.A. Sets Its Sights

for the best possible care in the most modern hospitals

MAJ. GEN. PAUL R. HAWLEY
Chief Medical Director
Veterans Administration
Washington, D. C.

TO CARE for the veterans of World War II, the Veterans Administration is launching what has been called the most gigantic hospital building program in the history of the world. Its estimated cost will be $448,000,000.

Much of this money already has been appropriated by Congress. The rest is in the works and will become available during the 1947 fiscal year.

183 Hospitals Planned

When this program is completed, the Veterans Administration will have 183 permanent hospitals of all kinds with a capacity of 151,500 beds. These will include 105 general medical and surgical hospitals; 49 neuropsychiatric and 29 tuberculosis institutions. Of the new hospitals which will be added to our present 98 plants, three are under construction, funds are available for 47 others and money for the remaining 30 has been requested from Congress.

To ensure that V.A. plans and builds the most modern hospitals, we have called in some of the country's most outstanding architects and the Army Engineer Corps. They will help us adapt the best in civilian hospital construction and planning so that the veterans will have the very best.

The four civilian architects who are working with us are: Carl A. Erikson, Chicago; Addison Erdman, New York City; Slocum Kingsbury, Washington, D. C., and W. T. Tusler, Minneapolis.

In building general hospitals the Veterans Administration plans to make them of four sizes: 200, 500, 750 and 1000 beds, depending on local needs. In most cases, the smaller hospitals will be staffed by full-time physicians and will have a lesser scope than larger hospitals, since it is impossible to have a large number of specialists assigned to them. It is estimated that approximately 25 per cent of patients cared for in smaller hospitals eventually will be transferred to larger hospitals for specialized care.

In order to improve the quality of medical care given to its patients, the V.A. is making arrangements for affiliation of those of its hospitals which are close to medical schools with such institutions. This plan will permit its patients to be treated by outstanding consultants, will provide professional stimulation for its physicians and may contribute new ideas regarding the administrative practices of our hospitals.

Obtaining adequate personnel to operate V.A. hospitals has been one of our greatest difficulties.

Seeks to Provide Best Care

The newly created Department of Medicine and Surgery, which operates the largest nonmilitary hospital service in the country, has only one aim—to provide for the veteran advanced and efficient medical care. In carrying out this program the Veterans Administration desires and solicits the assistance of all elements of the community.

For a time at least, we shall have too few physicians adequately to care for our patients so we have turned for assistance to the Army, Navy, Public Health Service and civilian hospitals.

In an effort to tap the resources of civilian hospitals a contract has been signed with the Michigan Hospital Association which will permit eligible veterans to obtain treatment in any one of some 200 civilian hospitals in that state.

Thirty-six additional state hospital associations, meeting in Chicago on February 8 and 9, ratified the proposal of the American Hospital Association to participate in the veterans general administration program along the lines of the Michigan contract.

Under the present law, contract hospitalization is permitted for male veterans with service-connected disabilities and for female veterans with either service-connected or nonservice-connected disabilities.

Program to be Decentralized

The magnitude of the operations of the Veterans Administration makes for unwieldiness in function and a process of decentralization is now in progress. The decentralization of the organization into 13 districts will permit the medical functions to be more sensitive to local needs. Although most patients desire to be hospitalized within their own communities, this will not always be possible. The need for specialized care will often make it desirable for the patient to be treated at a large hospital some distance from his home.

Fundamental in all our thinking regarding the veteran must be the realization that his problems are community problems and that they can be solved most effectively in relation to his rôle as a citizen. For though he has special problems at the moment, it is his wish and that of his neighbors that there be no cleavage between them. Village, town and city have recognized this and the local programs for helping his return to active citizenship must have our support. It is my hope, therefore, that the veterans' hospital in each community will be considered an integral part of the community's efforts to aid its soldiers-turned-civilian.

Methods of Measuring the *Quality* of Nursing Care—II

KEITH O. TAYLOR
Assistant Administrator, Peralta Hospital, Oakland, Calif.

USING the technic described in the first article of this series in the April issue, investigators studying bedside nursing technics gathered the material that is summarized here.

Table 1 presents a summary of nursing activities in hospital A, a general hospital. The summary is based on time studies of nine student nurses, six on a surgical division and three on a medical division. Table 2 provides a summary of the footnotes for the nine time studies, showing entries that occurred with the greatest frequency. These are followed by a report based on an analysis of the summaries. The tables appear on pages 60 and 61.

A similar scheme is followed for hospital C, an institution for the care of chronic diseases. In hospital C, however, a major part of the nursing is carried on by trained attendants under nursing supervision. Only six of these nursing attendants were observed, owing to the short duration of the study, but considerable information was derived from the limited sampling.

The nine nurses on whom individual studies were made at hospital A were stationed on the medical and on the eye, ear, nose and throat surgical wards. Observations were made over a period of thirty days.

The first division of the summary, "conferences with supervisors," has been separated from other duties because it represents a rather large single time element which includes the morning conference between the supervisor and the floor nurse. The shortest such conference reported was ten minutes, the longest, thirty minutes. In addition, all periods during which supervision interrupted a nurse's duties, for either instruction or criticism, are included. When it did not entail any delay in duty, other supervision was noted in footnotes to the individual studies.

For instance, nurse C spent ten minutes changing a sterile abdominal dressing, largely under supervision. On none of the three mornings that senior nurses were observed was any special supervision noted. Direct time with supervisors occupied about 9 per cent of the average nurse's time.

Charting has also been given a separate classification, although it might well be included in group A duties (see table 1). The segregation was made to throw emphasis on the amount of time spent in charting, in the light of the rather inadequate notes recorded. Only a small portion of the charting time is employed in entering the graphic record; the remainder of the time is spent in recording observational notes.

From a short summary of the charting, it is quickly apparent that, with one exception, these notes are for the most part of little use to the doctor. As a possible solution of the problem, more material might be entered in columnar fashion, limiting the observational notes to those that are strictly pertinent to care of the patient.

Some temporary gain may be obtained by emphasis on the importance of proper notes and observation, but the supervisor on the surgical unit put constant emphasis on charting, with only meager results. Charting requires about 12 per cent of the nurse's time and, consequently, it should be confined to such charting as may be valuable for the hospital and for her own personal development.

Rounds with doctors is the third separate classification which can scarcely be classified with other nursing duties. Such rounds comprised about 5 per cent of the average nurse's time, a fairly misleading average, since in four cases no time was so spent and in two cases the time spent exceeded 10 per cent of the nurse's entire morning.

The fourth division, group A duties, includes duties that are primarily professional in nature. The classification of these duties may be somewhat arbitrary, but it was felt that they were duties which combined certain skills with responsibil-

This is the second of three articles by Mr. Taylor on the adequacy of nursing service. The final article in the series will appear next month.—ED.

Condensed from master's thesis prepared for the University of Chicago hospital administration course.

TABLE 1—Summary of Nursing Activities—Hospital A

Duty	Time Spent (in Minutes)									Total	Average
Nurse	A	B	C	D	E	F	G	H	I	All	All
Conference with supervisors	28	40-	15	20	16	37	10	15	15	196	21.7
Charting	34	24	38	24	45	16	19	20	25	245	27.2
Rounds with doctors	18	..	15-	7	..	30	30	..	..	100	11.1
Group A Duties (1)											
Baths	24	..	5	..	..	..	16	23	16	84	9.3*
Medications	3	47	12	3	19	4	11	4	24	127	14.1
Dressings, binders	30	4	16	30	..	2	..	5	..	87	9.6
Special treatments, irrigations	..	16	..	2	14	15	21	19	7	94	10.4
Compresses	16	..	..	..	..	60	..	..	..	76	8.4
Preparation for surgery	15	..	..	..	..	..	..	..	..	15	1.6
Ice bags and hot water bottles	..	..	..	..	11	4	..	2	..	17	1.8
Temperatures	7	23	8	12	15	8	14	5	10	102	11.3
Enemas	..	..	13	..	30	..	..	11	..	54	6.0
Make patient comfortable	..	16	..	17	12	3	..	24	10	82	9.1
Total Group A	95	106	54	64	101	96	62	93	67	738	82.0
Group B Duties (2)											
Make beds	29	..	31	24	12	10	16	21	17	160	17.7a
Trays	5	75	20	13	14	10	30	16	37	220	24.4
Admit and discharge patients	..	..	13	..	..	..	..	..	..	13	1.4
Move patients—assist ambulatory	..	31	..	14	5	18	..	8	..	76	8.4
Sterilizing	..	..	..	..	13	..	..	..	..	13	1.4
Total—Group B	34	106	64	51	44	38	46	45	54	482	53.5
Group C Duties (3)											
Strip beds, make empty beds	8	7	5	2	6	..	3	..	6	37	4.1
Clean bedside stands, remove basins, soiled linen	5	..	8	3	8	..	23	19	25	91	10.1
Bedpans and urinals	8	7	3	..	11	5	3	1	..	38	4.2
Fix flowers	2	..	..	..	..	7	..	7	2	29	3.2
Look for dressing carriage, supplies	3	..	8	5	..	..	..	..	..	16	1.7
Telephones, messenger service	..	..	..	1	..	..	..	1	44	46	5.1
Total—Group C	26	14	24	22	25	12	29	28	77	257	28.5
Other a.m. care not observed	65	82	83	49	120	58	82	94	70	703	78.1
TOTAL TIME	300	372	293	237	351	287	278	295	308	2721	224.2

(1) Primarily professional. (2) Semiprofessional. (3) Nonprofessional.
*Average time for 8 baths was 10.5 minutes.
aAverage time for 19 beds was 8.4 minutes.

ity. This group accounts for some 36 per cent of the average nurse's time and includes many of her most important duties. Such duties are not generally amenable to standard time averages because they are not strictly routine and vary with the illness of the patient, the extent of dressings and other individual circumstances.

An average time for baths was computed, however; for eight baths the average time was 10.5 minutes. The best bath observed was given by a senior nurse and required sixteen minutes. It is probable that the latter figure represents a more nearly adequate time for the bath, and it appears reasonably certain that baths under the general average of 10.5 minutes are too sketchy.

The last of the duties listed here, "make patients comfortable," includes a variety of small tasks, such as special back care, and any additional time that can be allotted to such duties serves to increase patients' comfort.

The fifth classification, group B duties, includes those which may be considered semiprofessional in nature. They require more than 23 per cent of the average nurse's time. Two of the duties included in this group are among the four most time-consuming tasks. These are making beds

and serving trays. Although both these duties have a professional aspect when seriously ill patients are concerned, they can be performed by maids in many cases; for example, the routine delivery of general trays and the making of beds for mildly ill patients.

It is interesting to note in the individual time studies that the best average time for bed-making was credited to a second year student, who consistently completed her beds in six minutes, showing a well-coordinated technic. The poorest time was recorded for student A, who required thirteen minutes for one bed, though completing two others in eight minutes each.

The group C duties require more than 12 per cent of the average nurse's time and are essentially of a nonprofessional nature. With the exception of the second duty, "clean bedside stands, remove basins, soiled linen and so forth," no individual duty in this group requires much of the average nurse's time.

Maids Could Handle Flowers

Since it is necessary for the student to have a fair knowledge of housekeeping duties, the transfer of these duties to maids would probably not provide increased time for other duties commensurate with the instructional value of this work. Fixing flowers, although it may be of psychological value to the patient when the nurse directs her attention to the art of arrangement, provides nothing for the nurse and little for the patient when, as in most cases, nothing but the water is changed. This duty may well be relegated to maids unless it is more than routine.

The summary of special footnotes indicates to some extent the findings in regard to nursing notes and maid duties. Carelessness accounts for six entries, including the scratching of one patient, brushing against the sore shoulder of another, dropping medication, tearing a sheet, preparing the wrong medication and failing to sign for narcotics. The failure to have supplies available is probably due to incomplete adjustment to the central supply system. Constant care must be taken to adjust the floor supply situation so that delay or deferment of treatments and medications cannot arise.

Difficulties with some technics, difficulty in organizing procedures and

TABLE 2—Summary of Footnotes to Time Studies

NOTE	NO. OF INSTANCES
Could or should be maid's duty	9
Inadequate nursing notes	8
Carelessness	6
Supplies or medication not available	6
Inadequate back care	5
Difficulties in technic	4
Difficulty in organizing procedures	3
Delay in bedpans	3
Improper bandaging	2
Duties incomplete	2
Unnecessary delays	2
Sheet torn in making bed	2
Makes little inquiry regarding symptoms	1
Orders canceled before completion of preparation	1
Late medication	1
Treatments not carried out	1
Bedpan discovered in linen	1
Patient moved unnecessarily	1
Lack of definite assignment	1
Failure to assist patient	1
Uncooperative attitude	1
Lack of sensitivity	1
Lack of initiative	1

occasional improper bandaging are probably unavoidable among students, particularly first year students who have recently started floor duty. Some justification may be possible for a late medication if it is not too late, but no justification can be found for failure to carry out a treatment ordered. If the nurse is unable to complete her work, she should report to the supervisor so that some method of covering all work may be found.

The failure listed in these notes occurred with a first year student who had only recently started on the wards and was assigned a case load of six patients. This is probably too heavy a load for a student, as she will seldom have the experience and ability to organize and carry out her work properly unless a great deal of supervision time can be spared for her assistance. This student received little supervision during the morning of the reported incident and, while none of her patients was extremely ill, only one was ambulatory.

The uncooperative attitude and lack of sensitivity charged against one nurse appear more serious than later observation justified. The same nurse was observed for a short period at a later date and appeared to be far better. It is possible that fatigue or illness may account for the original showing.

Because of the nonroutine nature of the nurse's duties, most tasks varying with the illness of the patient, it is difficult to calculate a fatigue curve from time records. It seems obvious, however, that the nurse who has breakfast at 6:30 a.m. and is on the move practically every minute from 7 a.m. to 12 m. or 1 p.m. is subject to a not inconsiderable fatigue. In order to lessen this, it is recommended that mid-morning refreshments, possibly milk and crackers, be provided for all floor duty nurses. The time allowed for such

Table 3—Incidents Occurring With Greatest Frequency as Reported in Unusual Occurrence Sheets for One Year

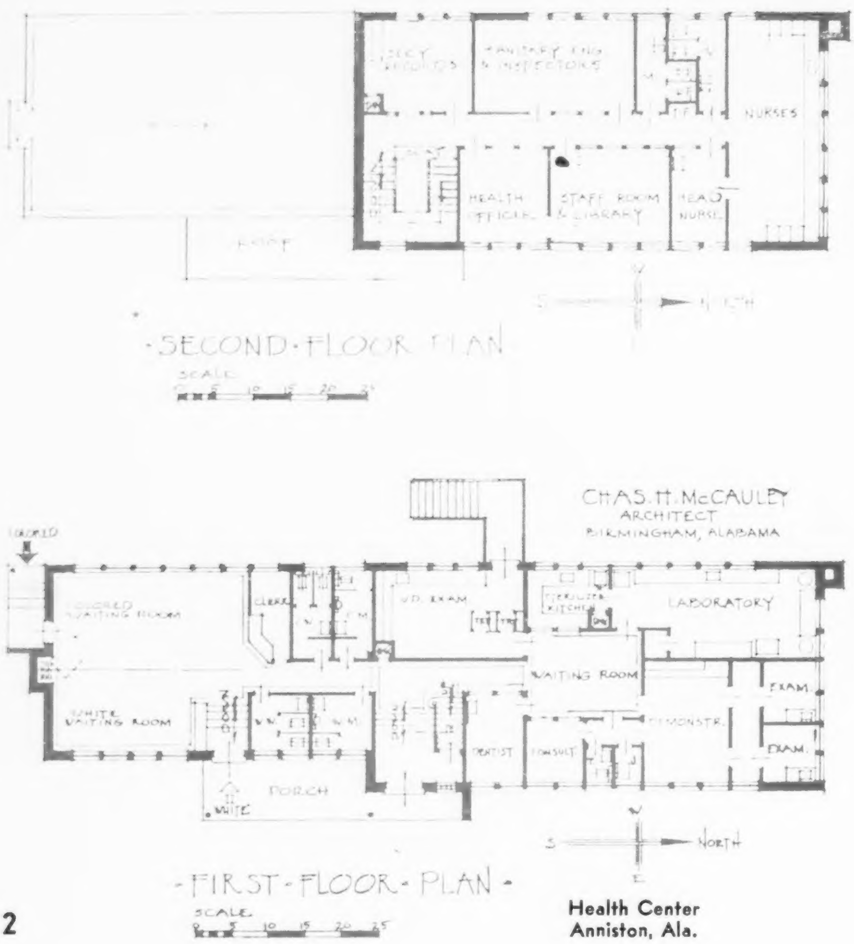
Patients found out of bed, no apparent injury	26
Patients found out of bed with resulting injury	14
Bedsores	11
Improper medications	7
Patients injured while in bed, i.e. fingers caught in back rests, etc	5

nourishment should be controlled by the supervisor.

Proceeding to the summary of unusual occurrences, table 3, it is important to note that accidents in the hospital have a qualitative relationship to nursing service. Hospital accidents can be studied best by comparison of accident reports over a period of several years and by comparative studies of several hospitals' reports over a similar period.

The over-all picture of nursing care at hospital A is reasonably good, but the study indicates opportunities for improvement in several directions. Organization, supervision and individual nursing care are all subject to revaluation in light of these data.

Health Centers Come Out of the Cellar



2

Health Center
Anniston, Ala.

IN ITS annual report of June 1944 the U. S. Public Health Service listed 1849 counties, or about 55 per cent of all counties in the United States, that were served with some organized health service. As requests for federal assistance poured in from crowded communities for new or improved health facilities, however, it was apparent that too frequently the health departments were housed as the unquiet stepchildren of the local governments—in basements, drafty attics, old residences, outworn school buildings. Equipment was often incomplete and sketchy.

Bad enough in prewar days, problems accumulated rapidly with the population shifts that visited boomtown conditions on many cities. Moreover, the armed services had made heavy inroads on local public health personnel.

The Federal Works Agency, charged by Congress with the administration of Lanham Act funds for the protection and safeguarding of the health of war-impacted communities, received literally thousands of requests from perplexed officials for public health facilities.

1

HARRY HEWES
Field Representative
Office of Information
Federal Works Agency

4

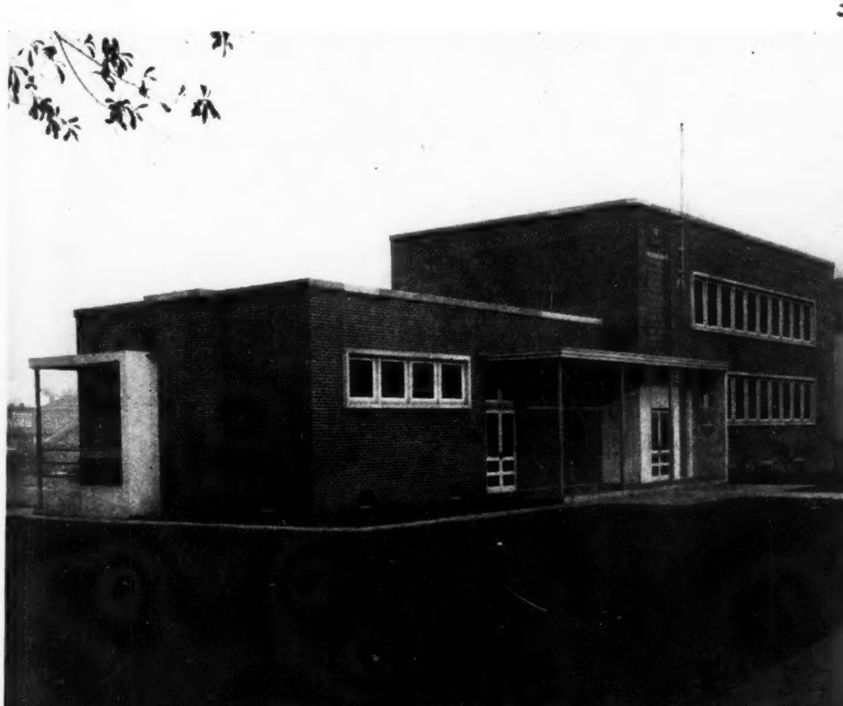
Maj. Gen. Philip B. Fleming, Federal Works Administrator, on whose desk the applications for federal funds landed, sought the assistance of U. S. Public Health Service officials in the necessary work of investigation and appraisal of need. The act specified that the need must be war-induced and that without the requested facilities the war effort would be impeded. General Fleming recognized maintenance and protection of public health as essential to the war production program, and applications usually were approved after the need had been certified by the U.S.P.H.S. These are typical cases:

The new county health center in Monroe, N. C., for example, is a single story building of brick and cinder blocks, with concrete floors and a built-up roof of frame construction. It was designed entirely for function, but with an eye to sightliness, and it marks a long step forward from the old county health offices upstairs over a feed store.

Administratively, the new health center will house the county health officer, two clerks, three sanitarians, five nurses and the vital statistical records. It also contains facilities for immunization, examination, x-ray apparatus and clinic; a laboratory; two waiting rooms, and a conference and assembly room. It stands 144 by 34 feet on an easily accessible corner and the over-all cost was approximately $52,000, of which $35,000 was in a Lanham Act grant. A wing provides fuel and other storage space.

Plans and photographs on these pages illustrate some of the projects undertaken by F.W.A. to meet health needs in war-impacted communities. The Monroe County Health Center (1), of one story cinder block construction, houses the health department staff and contains examination, immunization, x-ray and laboratory facilities. The Health Clinic built at Anniston, Ala., (2 and 3) is for general clinical purposes in addition to providing health administration offices. Okaloosa County Health Center (4) at Valpariso, Fla., serves Niceville and the surrounding area.

3



In 1940 the decennial census credited Valpariso, Okaloosa County, Florida, with a population of 250 persons. It had attracted 90 new residents in the decade since 1930. By Jan. 1, 1942, however, Valpariso had 3500 persons within or close to its corporate limits, including civilian personnel at Eglin Field, an airplane proving ground. The nearest hospital was in Crestview, 19 miles north, and the home of the nearest physician was 10 miles away.

Conditions were critical when, with state health department assistance, the Okaloosa County health office was established in conjunction with Walton County, and an application for F.W.A. money for a health center at Valpariso reached Washington. The need was unquestioned, and F.W.A. finally built the health center and equipped it as a war public works project. It was completed in May 1943 and cost $20,509.

Cheyenne, Wyo., also experienced an unprecedented population growth with near-by Fort Francis E. Warren entering war status. Laramie County health authorities, overtaxed and with finances depleted in the effort to meet the new situation, received F.W.A. funds for a federally constructed health center. It is an L-shaped building, approximately 62 by 74 feet, of concrete, cinder block

and face brick construction with a full basement. It was completed in October 1944 at a cost of $40,396, including equipment.

The health authorities of McCracken County, Kentucky, housed in an old two story Paducah residence, incommodious and in need of repairs, managed somehow before Pearl Harbor. However, with three Army camps, a Navy preflight school and an aviation cadet school receiving big complements, and with the Paducah industries and the ordnance plant attracting thousands of new workers, newer and better health facilities were needed. Necessity for pressing the malarial control program increased the burden.

For construction of a one story, part basement building to provide additional health center facilities, an F.W.A. allotment of $95,357 was approved for federal construction.

Basement Offices Inadequate

The health department of Forrest County, Mississippi, was housed in several small rooms in the courthouse basement in Hattiesburg before the war impact and the consequent boost in population. The federally built war public works project here cost approximately $68,520, was completed in July 1943 and provides facilities for rapid treatment of venereal disease, and maternal and child care clinics, as well as for the usual administrative activities and laboratories.

A federally constructed two story health center costing approximately $52,500 was built at Anniston, Ala., taking the Calhoun County health offices out of the courthouse annex. A general hospital and nurses' home also were built as war public works projects in this community.

The basement of the new F.W.A. health center in Pendleton, Ore., which houses the Umatilla County health offices, has been fitted up as a lecture room, where the educational features of the public health program will be emphasized. Other facilities in the new one story building include x-ray equipment, laboratories, clinics and waiting rooms.

The cost for the 173 health centers for which F.W.A. made grants or allotments has been estimated at $6,613,750 and includes $766,994 provided by the applicants. The 111 federally constructed health centers were built at a cost of $5,846,756.

How Shadyside Prepared To Meet Disaster

THE possibility of a complete shut-off of electric power during a strike of the power company union struck the Shadyside Hospital, Pittsburgh, as it did the city, with terrific suddenness one morning last winter. Emergencies are nothing new to us. We meet them day and night throughout the year. But to care for our patients without electricity for light, for x-rays, for elevator service, for incubators, for refrigeration, for laundry and other essentials would create a real problem!

All day and on into the night we made every possible preparation to meet this emergency. Flashlights and candles were procured for patients' rooms and nursing stations. Battery lights were made ready in the operating rooms, delivery rooms and emergency department. Emergency lanterns were procured for the power house. The coal bin was filled. Extra gasoline was purchased for the ambulances and other vehicles. Menus were revised, in case dairy products, baked goods and perishable foods should be cut off. Patient food supplies were moved to each floor, in case elevator service should be stopped. The electric washing machines, dryers and mangles in the laundry operated continuously to provide a reserve supply of clean linens for patient care.

The hospital male volunteers, Red Cross nurse's aides and other volunteers were alerted and stood ready to come to the hospital if needed. Offers of assistance poured in from the women's auxiliary groups, Boy Scouts, hospitals outside the threatened area and countless other friends. The Mine Safety Appliances Company lent us 40 miners' safety lamps.

The next day there were no street cars. Some of our employes got up as early as 4 a.m. to walk to work. We had to send the station wagon to pick up many key personnel. Arrangements were made for many general duty nurses and others to stay over night. The hospital census was 315, and only 14 more patients were admitted during the day, seven of them obstetrical cases. One patient, scheduled to go home, had to stay in the hospital because she could not be alone in a house without heat or light.

The dispensary was unnaturally quiet. Only five patients were able to come for the scheduled clinics, but operating rooms had a heavy schedule because many operations could not wait. We worked with a minimum of lights and elevator service to save power. Volunteers from different departments helped the laundry complete the processing of linens for the floors. Few visitors could get here to cheer sick friends or members of the family. After sundown a dim, hushed atmosphere pervaded the hospital halls and corridors. The medical staff meeting scheduled for that night was postponed. What would the morning bring?

Second Strike Called Off

Happily, the morning brought an end to that first strike and we felt tremendously relieved. A little later we went through much the same thing, until the proposed second strike was called off at the eleventh hour. In the meantime the board of trustees authorized the purchase of auxiliary power equipment (at an installed cost of about $5000) which was rushed to the hospital and immediately set up.

Our patients remained calm and unworried throughout. Though sick and unable to care for themselves, they seemed confident that somehow, some way, we would provide for them. This, we think, is the highest tribute our hospital could receive.

Condensed from the "Voice of Shadyside," published at Shadyside Hospital, Pittsburgh, March 1946.

When *ADOPTION* Is in Question

Some of the legal, social and psychological questions regarding adoption procedures that the hospital administrator may be called upon to answer

DOUGLAS E. LAWSON

Professor of Education
Southern Illinois Normal University
Carbondale, Ill.

UNTIL more adequate legislation provides some intelligent social control for the care of orphaned children, administrators of hospitals will continue to be faced with a responsibility that society has not yet assumed.

Even then, in all likelihood, the hospital administrator will be called upon to exercise a discretionary function for society in recommending procedures for specific cases involving both orphaned children and so-called "illegitimate" babies.

Regardless of legislation, it will always be important for the hospital official to be aware of certain social, psychological and administrative problems that will bear upon his own action and recommendations relative to facilitating (or sometimes discouraging) an adoption.

This article is an attempt to summarize what appear to be the major points of importance governing correct procedure in administrative or consultative practice regarding adoption.

Questions That May Be Asked

Among the questions that are raised the following are of relatively high frequency:

1. Should the child's name be changed?
2. Should the birth certificate itself be changed to show only the new name?
3. Is it safe to deal with a private adoption agency?
4. Should a child be taken on trial before adoption?
5. Should adoptive parents try to become acquainted with the biologic parents of the child?
6. Should adoptive parents be told who the biologic parents are? How much should they be told?
7. Does the adopted child have legal inheritance rights from his adoptive parents? From his biologic parents?
8. Do adopted children, generally speaking, make satisfactory life adjustments?
9. When is it desirable or undesirable to adopt an illegitimate child? Should adoptive parents know he is illegitimate?
10. What importance attaches to the age of the adopted child?
11. What safeguards need to be taken to prevent adoption of a child with inherent weaknesses?
12. In advising adoptive parents, what attention should be given to basic intelligence of the child? Of the adopting parents?
13. What procedure is necessary to guarantee that the adoption will be legal and permanent?

Finally, if prospective adoptive parents are to be advised on the adoption and care of the child, what other information, perhaps unasked for, should be given them?

For the sake of ready reference, these questions will be treated here in the order in which they have been stated.

1. *Should the child's name be changed?* Clinical workers and legal authorities everywhere are agreed that, if the child is actually adopted, his name should be legally changed at the time adoption papers are taken out.

2. *Should the birth certificate itself be changed to show only the new name?* Yes. Otherwise the child faces the chance of innumerable embarrassments during his life: in enrolling in school, in applying for a job, in applying for licenses or passports and in many other situations. If the law provides for a new certificate showing only the adoptive name, this name should appear on the certificate exactly as if, at the time of his birth, the child had been born into his adoptive home.

Records Should be Kept

To make it possible, however, for genetic research and other studies to be carried on, and to provide possible evidence which may be sought at a later date, the original birth certificate, together with all court records pertaining to the adoption, should be sealed and filed. These records then should be available only upon court order and for good cause shown.

3. *Is it safe to deal with a private adoption agency.* The laws of the

"SERVICES FOR UNMARRIED MOTHERS AND THEIR CHILDREN"

One out of every 25 babies in our country is "illegitimately born," and the mothers of these children—half the time—are themselves little more than children, between 15 and 19 years old.

The difficulties these unmarried mothers and their children face present a challenge to hundreds of communities.

Providing the many services mother and baby may need—social casework, financial assistance, medical, nursing and hospital service, legal advice and assurance of a good family life for the baby—takes coordinated planning on the part of many community agencies if the job is to be done well.

What services should be available to unmarried mothers, how communities can plan to meet these needs and what resources are available to local communities from the Children's Bureau of the U. S. Department of Labor, the bureau of public assistance of the Social Security Board and the American Red Cross are described in a bulletin entitled "Services for Unmarried Mothers and Their Children." These three agencies cooperated in its preparation.

Here is a guide to planning, useful to community leaders, local public officials and private agencies that are concerned with giving the baby born out of wedlock a fair start in life and his mother a helping hand over a difficult period.

various states are so diverse that a categorical answer cannot be given to this question. In some states there are no other agencies. But, in general, advice should first be sought from the state department of public welfare concerning the agency in question, or advice may be sought from a competent judge of a probate or children's court.

In no case should prospective adoptive parents deal with or through a private person who is not officially licensed by the state or under supervision of the state welfare department in the discharge of specifically designated functions in relation to adoption.

Children Made Prisoners

Some private agencies are little more than child markets. Others, operating on political preferment and paid so much per day per child in custody, are given the power to approve or disapprove adoption petitions. Naturally, since the children constitute their source of profit, they refuse most requests, keeping the children as perpetual wards—and prisoners.

4. *Should a child be taken on trial before adoption?* The professional men and women who have been closely connected with the clinical aspects of adoption seem unanimously agreed that such a probationary period (preferably of a year) should be compulsory, for the protection of both the parents and the child. There seems no valid argument to oppose such probationary period, provided proper legal safeguards protect the right of adoption at the end of the trial period. Such a period of probation should be strongly advised.

5. *Should adoptive parents try to become acquainted with the biologic parents of the child?* Both for psychological and legal reasons, no. If it is at all possible, this should certainly be avoided.

6. *Should adoptive parents be told who the biologic parents are? How much should they be told?* No. And, for their peace of mind and that of the child, the less they know specifically about the biologic parents the better. If they are more interested in the child's ancestors than in the child as a person himself, they probably should be discouraged from adopting. There also is the danger that, if they know a little about the parents, they will perpetually use this little as a clue in their effort to discover more. Obviously, if they are to accept the child as their own, this attitude is unwholesome.

However, certain general information can be given if it is of such nature as to serve as no possible source of worry or prejudice. For example, the adoptive parents can be told that the biologic parents were healthy, that they were intelligent, that they were of good character. More specific information should be withheld if at all possible.

Legal Advice Needed

7. *Does the adopted child have legal inheritance rights from his adoptive parents? From his biologic parents?* Specific information on this point must be sought from competent legal authority in the state in which adoption is made. Examination of the adoption laws of the 48 states shows a chaotic condition in the laws. In fact, courts in some states are in disagreement in interpreting the clauses relating to legal inheritance rights. Hence, although the law in a given state may appear to read one way, judicial precedent may have established a contrary interpretation. Again, a competent judge of a probate or children's court is usually the person from whom to seek information on this question. County judges may be incompetent.

8. *Do adopted children, generally speaking, make satisfactory life adjustments?* In what appears to have been a good research study published by the State Charities Aid Association in New York in 1924, Sophie van Senden Theis reported the results of an investigation of 910 such children.

By establishing various technics of measurement she found that 615 had definitely "made good." In general, it appears that under proper guidance, adoption should not prejudice the child's chances to make as satisfactory life adjustment as do other children in the family, provided the child started out with as good biologic and physical traits.

9. *When is it desirable or undesirable to adopt an illegitimate child? Should adoptive parents know he is illegitimate?* Actually, the illegiti-

mate children have a better average chance than legitimate foundlings have to inherit desirable traits. This fact is obvious if one realizes that a high proportion of the abandoned illegitimates are simply the offspring of healthy young people whose discretion and financial competence were both a bit weak. Or, having no adequate solution to the social problem of facing the world with an illegitimate child, a young mother may choose to turn her baby over to the state welfare authorities. But if the child is legitimate and has actually been abandoned by its legal parents, the chances are that they are of such indigent or incompetent stock as to prejudice their offspring's chances of inheriting fine traits which they themselves lack.

Parents Should Not Be Told

Adoptive parents should not be told that the child is illegitimate. If they are unwilling to accept him for what he is, and with that understanding, then they probably are undesirable adoptive parents. There appears no good reason why any parent of an adoptive child should know that the child is illegitimate.

It is interesting to note a tendency in legal enactments today toward recognition of the plain fact that, since all children come into the world in the same manner, there is no such thing as an "illegitimate child." The relationship of his parents may have been illicit. But the child is no different from the child he would have been had certain legal technicalities been observed.

10. *What importance attaches to the age of the adopted child?* This question has no single easy answer. If adoptive parents have a child in the home, they may well be urged to adopt one near his age. If they have lost a child that they wish to "replace" by the adoption, they may be urged to consider the fact that a child of about the age of the one they have lost will probably come nearer actually to taking his place than a younger child would.

Some authorities urge that the adopted child be taken as young as possible, which is right from a psychological point of view in considering the factors of early training, conditioning and emotional attachments. But it leaves out of account the fact that very young children are in much greater demand, while thousands of older ones lose all hope of being adopted simply by reason of their being older.

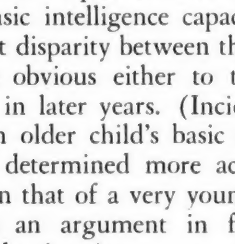
Again, it seems reasonable to suggest that, if the parents are quite young and have no child, a young child would be appropriate. But if they are more mature, they may be able to do more for an older child between whose age and theirs the gap is not too great.

11. *What safeguards need to be taken to prevent adoption of a child with inherent weaknesses?* The state, of course, should provide full clinical service in both medical examination and the use of a case history of the child and his biologic parents. Sometimes, where no other service is available, the family physician of the child's biologic parents can give vital information. But full clinical data should be obtained when possible.

12. *In advising adoptive parents, what attention should be given to basic intelligence of the child? Of the adopting parents?* Careful attention needs to be given here. The capacity for intelligence is not independent of genetic factors. The child and his new parents should be of such basic intelligence capacity that no great disparity between them will become obvious either to them or to him in later years. (Incidentally, since an older child's basic capacity can be determined more accurately than can that of a very young child, here is an argument in favor of older adoptions.)

Particularly if there are other children in the adoptive home, care should be taken in this matter. Any large discrepancy between the adoptive child and his adoptive brothers or sisters can be the source of sad embarrassment to one or the other as they grow older.

13. *What procedure is necessary to guarantee that the adoption will be legal and permanent?* Consult the state agency in charge of adoptions or consult a court of competent jurisdiction.



Finally, there will be other questions that prospective adoptive parents ask. Some of them can be readily disposed of.

"Will we learn to love the child as if he were our own?"

The answer may appropriately be given: "Yes, if your love of children is genuine!" Or, more diplomatically, it may be a clarification of the fact that parental love is not a mystic tie that biologically links a parent to his "own" child. Rather, it is physiological and sociological and psychological, growing largely from the postnatal care of the child, the life-long relationship itself. The glandular factors of maternal love, strong as they may be, do not attach the mother emotionally to a specific offspring but to that offspring upon whom she can lavish her maternal care.

"Will the child learn to love us?"

"Yes, if you treat him in the way that would make your biologic offspring love you."

Discover Child's Opinion

"Should we tell our friends and neighbors that the child is adopted?"

"It probably will be impossible to keep them from knowing. But if you move to another state and prefer not to have the fact of adoption known, use your own judgment. But casually and somewhat indirectly try first to get an expression of the child's opinion on this. You might, if you are not careful, give him the opinion that, after all, you are a little ashamed of the adoptive relationship."

"Have any adopted or foster children turned out really to amount to anything?"

"To the relative degree of success that you wish to attribute to Moses, Leonardo da Vinci and Abraham Lincoln, all of whom were in that class."

"Can the biologic parents ever take him away from us?"

"No, provided the adoption is legalized by a court and you remain competent parents."

"How should we treat the child?"

"Exactly as you would treat a child biologically your own. The important thing is to remember that your new parenthood is not a 'foster' parenthood. It *is* parenthood—or will be if you make it so."

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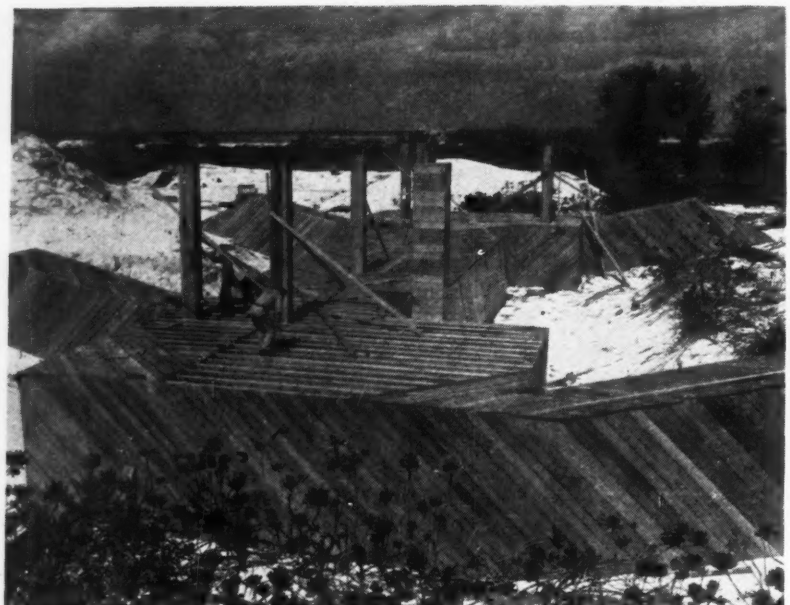

CONSTRUCTING A NAVY UNDERGROUND HOSPITAL: (1) The hospital is built in a saucer, scraped by a bulldozer. (2) The work of burying the hospital goes on while the interior trim is being completed. (3) Buried wood work is covered with waterproof paper and all seams are heavily tarred.

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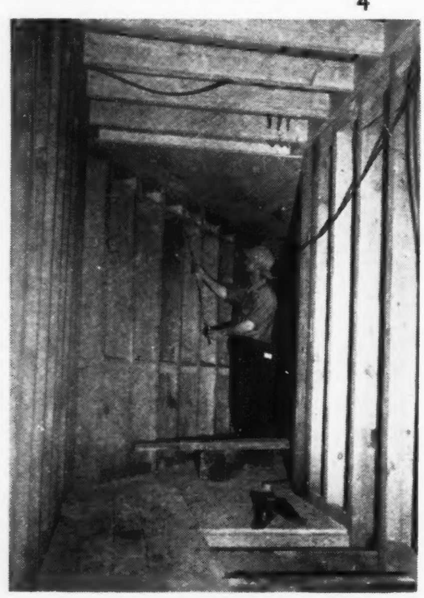

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(4) Heavy timbers are necessary to carry the covering of sand. The space between them is utilized for storage lockers and cabinets. (5) Corridor leading to the operating room. (6) Right foreground: head house for sump pump; right background: gopher-hole entrance to hospital; left background: vents of buried hospital unit. (7) Gopher entrances are protected by sandbags and burlap-covered doors. (8) Aerial puzzle: find the buried hospital. After the bushes have been planted over it the vents are almost invisible from the air.

Navy Hospitals Underground

R. ADM. LUCIUS W. JOHNSON
Medical Corps, U. S. Navy

HOW shall we provide hospital care for victims of disaster? This is a matter of concern to a surprisingly large number of persons. Not only are the Navy, Army and Red Cross obligated to act when disaster strikes, but civil governments and all the hospital world must be prepared.

Fifteen years of association with Red Cross disaster relief work, also experience in two large and a number of small wars, have impressed on me one salient fact. Man-made disasters, such as those of war, produce problems of hospitalization similar to those which follow nature's upheavals. The war is over now, and everybody wants to forget it as quickly as possible. That is a perfectly normal reaction, following the travail we underwent while the struggle was on. But the lessons learned while our imaginations were stimulated by the war should not be forgotten, if they can be applied to the problems of peace.

The necessity of dispersion and concealment influenced many details of hospital construction in combat areas. While those conditions are seldom important during peace, the ingenious expedients that worked out so well may often be applied.

Did earth-moving machines win the war? Perhaps not, but nobody who saw the C.B.'s use them to change the face of nature in the Pacific islands could doubt that they were an important agency in our success. The Japanese prisoners who watched them at work shook their heads and said: "We have no chance against an enemy so powerful." Some of the islands were multiplied several times in above-water area to make them suitable for bomber bases. From high in the air they looked like yardsticks with wads of chewing gum stuck on the edges. If you landed there you would find that the bulges were crowded with shops and barracks, while the hospitals were under the ground.

Most of the atolls were only a few feet above water level. One outstanding exception had a dune, known as Mac's Mountain, which reached an altitude of 15 feet. Their porous soil, of sand and coral, was hardly ideal for subterranean construction and there were difficult engineering problems, some of which are illustrated by the photographs.

The first step in building the underground hospital was excavation by a bulldozer, nearly to the water line, perhaps a depth of two or three feet. Construction was of very heavy timber, to carry the covering of sand and to resist the shock of a possible bomb hit. Over this was a covering of heavy waterproof paper, with all seams and joints thickly tarred. Forced ventilation was through shafts which extended above ground. Spaces between the heavy uprights were used for storage of materials. After construction was completed the whole building was covered with several feet of sand, in which bushes (Scaevola frutens) were planted for camouflage.

The gopher-hole entrances were concealed by burlap-covered doors and were protected by sandbags. To reduce the humidity, a sump was dug in the center of the group of buildings and a pump installed. Usually it ran night and day.

Early settlers on our western plains learned to survive in spite of adversity by emulating the gopher and building their homes beneath the sod. It is not difficult to imagine calamities, caused by man or nature, which might force us once more into homes and hospitals underground.

The ideas and opinions here expressed are the private views of the writer and do not represent the policy of any government department.

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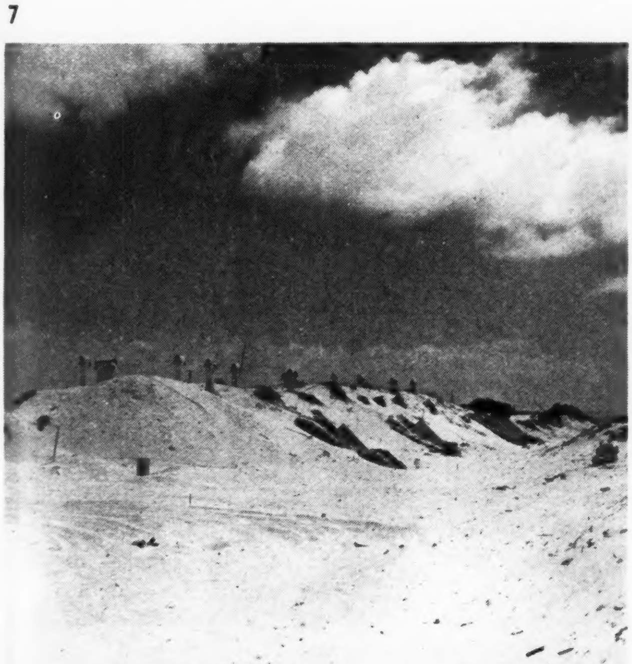

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Let's Make Friends With Funeral Directors

W. A. HACKER

Superintendent
McKeesport Hospital
McKeesport, Pa.

BUSINESS relations between hospitals and funeral directors are not always as satisfactory as they might be. This is unfortunate because these two groups constantly deal with each other, and it is to the advantage of the hospital, the funeral director and the general public if a cordial relationship exists between these two groups.

Many of these differences arise from misunderstandings, but we must also admit that some of them are caused by negligence and indifference on the part of either the hospital or the funeral director.

Hospitals are becoming more and more public relations minded and a great deal of effort is exerted by them to create a better feeling and understanding between the general public and themselves. Hospital administrators recognize the fact that they are becoming more and more dependent upon the good will of the public for the very existence of their institutions.

Relations Can Be Improved

This good will should also extend into the relationship between themselves and the funeral directors, and the hospital administrator will do well to take this fact into consideration. He will find that there are many small services which can be rendered by hospital personnel that will greatly reduce inconveniences to the funeral director and will certainly create improved relationships.

On the other hand, the funeral director must also realize that there are certain principles involved that are absolutely necessary from the standpoint of the hospital and, before becoming critical, he should endeavor to obtain all the facts in connection with any misunderstanding.

Most hospitals require funeral directors to obtain a written authorization from the nearest of kin to remove a body from the hospital. There should be no objection to this practice, inasmuch as it affords legal protection to both hospital and funeral director. However, the method of obtaining this permit is highly important to the funeral director.

Hospitals should, and in most cases do, obtain the permit at the time of death if the nearest of kin is present, and he usually is. It should be unnecessary for the funeral director to make a special trip to the home of the deceased in order to obtain this permit. In fact, in some cases, when death is imminent, families arrange for their funeral director before death occurs. This, of course, is a delicate situation and must be handled tactfully.

In some instances, although this privilege should not be abused, a hospital will allow a reputable funeral director to remove a body without a permit, provided one is obtained and returned to the hospital as soon as possible. It is a good plan for funeral directors to obtain blank permits from hospitals, because there are occasions when extra trips can be avoided by calling at the home of a client for a signature before going to the hospital.

Sometimes deceased patients have only distant relatives and friends who assume responsibility for making funeral arrangements and, at times, two such persons will disagree upon a single funeral director and each will sign a permit and insist that the body be released to the funeral director of his choice. This places the hospital in an embarrassing position, sometimes involving it in controversies with funeral directors through no fault of its own. Such a situation demands tactful handling on the part of the hospital administrator, who sometimes finds it necessary to refer such cases to the coroner's office for solution.

There have been occasions when hospital employes have been accused of attempting to influence relatives of deceased patients to engage certain funeral directors. If such a practice exists, hospital authorities should make every effort to stamp out this evil.

The death certificate is another source of annoyance to the funeral director. Unfortunately, the attending physician is not always present when death occurs, making it impossible to obtain a death certificate before the body is removed. It is not the practice of hospitals to permit interns to sign death certificates and it is, therefore, necessary for the funeral director to make a second trip to the hospital.

Here is a real opportunity for the hospital to cement a friendly relationship with the funeral director. Sometimes hospitals place the responsibility of obtaining the certificate from the attending physician upon the funeral director. This is not good practice because it may be difficult for the funeral director to find the physician in his office or he must make more than one trip to his office or, if the office is filled with waiting patients, he must sometimes lose valuable time awaiting his turn.

Hospital Should Be Responsible

It is much better if the hospital assumes this responsibility. If the certificate is not obtained at the time of death, it can be when the physician next visits the hospital, which is usually on the same day or the following morning. One of the hospital departments, preferably the business office or the record librarian, should be responsible for seeing that the certificate is obtained as soon as possible and that the funeral director is notified when it is available.

Necropsies are probably the most controversial issue between hospitals and funeral directors. This is un-

fortunate because they are necessary in the promotion of science and in the training of interns and residents. Staff physicians, too, learn much from postmortem examinations. The American Medical Association and the American College of Surgeons require hospitals to perform necropsies in at least 15 per cent of deaths in order to qualify for full approval.

In view of all these facts, it can readily be understood why necropsies are necessary, and that such examinations will probably always be made, so that hospitals and funeral directors should make every effort to cooperate in this function. The necropsy should be performed immediately after death or as soon as possible. It should be recognized that it is much more difficult to embalm a body many hours after death, and the hospital should make every effort to see that the body is made available to the funeral director as promptly as possible. The hospital should also take the responsibility of notifying the funeral director as soon as the necropsy is completed.

Care should be taken by the pathologist to see that the body is delivered to the funeral director so that satisfactory embalming can be done. There have been complaints that sometimes vessels are not properly tied off or that careless incisions are made which are difficult to cover. This is unfair to the funeral director and makes his work unnecessarily difficult. Most funeral directors' associations have an expert available who is qualified to perform necropsies and who is called upon to demonstrate a technic satisfactory to both the hospital pathologist and the funeral director. It is a wise pathologist who invites this expert to perform at least one necropsy in his presence. Many of the controversies and misunderstandings between pathologists and funeral directors can thus be eliminated.

Funeral directors are sometimes accused of prevailing upon relatives of deceased patients to refuse permission to perform necropsies. This should not occur. Arrangements should be discussed by hospital authorities and relatives of the deceased; the funeral director should take no part in this discussion. If a misunderstanding exists between a hospital and a funeral director with regard to necropsies it is far better that they attempt to correct it rather than work against each other.

Inasmuch as contacts between hospitals and funeral directors are inevitable, it will be to the best interests of all concerned if a pleasant relationship exists between them.

Collection Agencies and the *Law*

A COLLECTION agency can be defined as an individual, a company or an organization engaged in the business of adjusting accounts for creditors. When a hospital renders services to a pay patient on credit a debt is created. If the hospital is unable to obtain payment through its own efforts, it may decide to employ a collection agency, which will then get in touch with the debtor personally by "lay" means. Such agencies accept the account for collection on a contingent basis and remit the proceeds to the hospital after deducting their service charges.

Advise Employing Attorney

Should the agency be unsuccessful in its effort, it may advise the hospital to place the claim with an attorney suggested by it. If the attorney obtains payment without suit, he remits to the agency part of the fee agreed upon between the agency and the hospital. When legal proceedings are necessary, the attorney may request that the court costs or suit fees or both be advanced to him. As a rule, the hospital forwards these charges to the agency, which sends the money to the lawyer. No reputable agency attempts to get part of these costs; if these costs are recovered they are returned to the hospital.

Many of the agencies select the attorney from a "law list" of bonded members of the bar, the bonding company undertaking to protect the hospital if the lawyer fails to account for any funds collected by him. The careless or dilatory lawyer may be removed from the list.

The less reputable collection agencies may resort to questionable practices, such as the splitting of legal fees with attorneys, usage of forms that simulate court documents, the giving of legal advice, the filing of suits in courts of record, the threat of legal proceedings and solicitation of claims in behalf of attorneys. Lawyers may not resort to unethical practices; they may not divide a fee for legal services except with another attorney based upon a division of service or responsibility. Some persons think it unethical for a lawyer to receive an account for collection from a lay agency when the collection commission is to be split with the agency.

Hospital Should Choose

Reputable collection agencies can and often do perform exceedingly useful service to hospitals. However, the hospital should be at liberty to select its own lawyer; if the agency recommends the lawyer it should offer the hospital a choice of a number of them. There should be no objection to having the attorney advise the hospital directly of what steps he is taking in its interest or consult with the proper official. The agency should make available to the lawyer the preliminary information which it may have obtained concerning the debtor.

Collection agencies have maintained that the "furnishing of lawyers" does not constitute the practice of law. Statutes have been passed in the various states restricting the

This article was written by an attorney.

activities of collection agencies to prevent them from engaging in acts tantamount to the practice of law. The practice of law embraces the preparation of pleadings and other papers incident to actions, and the management of such actions on behalf of clients before judges and courts. In addition, legal practice includes the preparation of legal instruments of all kinds and the giving of advice to clients.

What Agencies Cannot Do

The American Bar Association's committee on unauthorized practice of law has adopted a declaration of principles as follows:

"It is improper for a collection agency

"1. To furnish legal advice or perform legal services, or to represent that it is competent to do so, or to institute judicial proceedings on behalf of other persons.

"2. To communicate with debtors in the name of an attorney or upon the stationery of an attorney; or to prepare any forms of instrument which only attorneys are authorized to prepare.

"3. To solicit and receive assignment of claims for the purpose of suit thereon.

"4. In dealing with debtors to employ instruments simulating forms of judicial process or forms of notice pertaining to judicial proceedings, or to threaten the commencement of such proceedings.

"5. To solicit claims for the purpose of having any legal action or court proceedings instituted thereon or to solicit claims for any purpose at the instigation of any attorney.

"6. To assume authority on behalf of creditors to employ or terminate the services of an attorney or to arrange the terms or compensation for such services.

"7. To intervene between creditor and attorney in any manner which would control or exploit the services of the attorney or which would direct those services in the interest of the agency.

"8. To demand or obtain in any manner a share of the proper compensation for services performed by an attorney in collecting a claim, irrespective of whether or not the agency may have previously attempted collection thereof."

Corporations, as well as laymen, are prohibited from practicing law. However, a corporation may employ an attorney to attend to its own immediate affairs, but no lawyer may accept employment from an organization to render legal services in any matter in which the organization as an entity is not interested.

There have been a number of cases which hold that charitable corporations may not render legal services for individuals or other groups. In Illinois, the Motorists' Association of Illinois was incorporated "not for pecuniary profit." Its certificate of incorporation stated that it was to operate a nonprofit corporation for the benefit of its members; to supply information to motorists; to obtain beneficial legislation. The corporation maintained a legal department with attorneys employed to handle collision claims, furnish counsel to appear in court for members charged with motor vehicle law violations and render other services.

In a proceeding brought to restrain the corporation from carrying on these activities, the court said that these services undoubtedly are the practice of law. The corporation had contended that it was a corporation "not for profit" and therefore not prohibited from practicing law; that the statute which prohibited corporations from practicing law did not apply to "corporations not for pecuniary profit."

Corporation May Not Practice Law

The same section nevertheless provided that no corporation may render legal services that can be performed only by a lawyer and that no corporation may solicit employment for a lawyer. While it is within the power of the legislature to pass an act prohibiting corporations from practicing law, the legislature has no authority to license a person to practice law. It is a well-settled rule that a corporation cannot be licensed to practice law and this rule applies to corporations organized not-for-profit.

Another proceeding was brought against the Chicago Motor Club to restrain it from engaging in the practice of law. This organization had high prestige and comparatively high standards; it was also a nonprofit corporation and engaged lawyers to perform legal services for its members. The corporation contended that it was a not-for-pecuniary-profit organization and that the results obtained were of great benefit to its members and the community; that its lawyers were efficient and practiced in legitimate fields of law.

The court held, however, that no matter how beneficial its many purposes and services were to its members the corporation could not offer legal services to them. "The fact that respondent was a corporation organized not-for-profit does not vary the rule."

In the city of New York, the voluntary hospitals decided to incorporate a collection agency for the purpose of collecting unpaid bills for member hospitals. For that purpose a nonprofit corporation was formed in 1939 under the name of the Hospital Credit Exchange, Inc. The claims of hospitals were assigned to the collection corporation by the hospitals employing the agency. Collection letters would be sent out to debtors in the name of the agency demanding payment and stating that if the charges were not paid the matter would be referred to an attorney. An attorney was employed by the agency on a regular salaried basis and would institute suit in the name of the Hospital Credit Exchange, Inc.

Status of Credit Exchange

One of these suits recently came up in court and the question arose as to the right of the collection corporation to maintain the action. The court held that the Hospital Credit Exchange, Inc., was not a charitable corporation, despite the fact that its customers were charitable hospitals; that any collection agency could incorporate as a nonprofit corporation for the purpose of serving charitable organizations, and thus its staff could remunerate itself handsomely after distributing so-called profits among its clients.

It was the contention of the Hospital Credit Exchange, Inc., that the penal law, which it was held to have violated, had been amended to allow charitable corporations to accept assignments of claims. To that argument the court said that such assignments of claims could be accepted by a corporation for its own benefit but not for the purpose of enabling it to bring suits for the benefit of others in order to earn a fee for itself. The employment of an attorney, the taking of the assignments, the bringing of actions were all stated to be the unlawful practice of law by corporations.

Accounting Serves Four Purposes

- To Furnish Current Information
- To Reveal Accurate Cost Data
- To Anticipate Expenditures
- To Permit Better Reporting

ORVILLE GUENTHER
Comptroller
Milwaukee County Institutions
Wauwatosa, Wis.

ACCOUNTING SYSTEMS are often compared with historical documents because they serve only to record financial data. If this is the only aim of an accounting system, then no more serious indictment can be made. Unless accounting information can be made currently available as an aid to the administration of hospitals, we miss the real objective of a good system.

An accounting system for a hospital should have four definite goals or objectives:

1. It must furnish information to administrative officials that will help them manage the institution in the most effective manner. To accomplish this, the information must be current. Reports on expenditures and costs should reach administrative officials in time to be of value in watching future expenditures. The information should be available in a usable form in sufficient detail to accomplish this objective. Administrative officials should be encouraged to use the information after it is submitted.

Cost Data Must Be Accurate

2. The accounting system must reveal accurate costs to be used in obtaining adequate and equitable reimbursement for services rendered. This is true whether the hospital is a voluntary or a public institution. In the case of voluntary hospitals, the costs of various services rendered must necessarily influence the rates to be charged, which ultimately result in adequate revenue. In the case of public institutions that care primarily for indigent patients, the amount to be charged is definitely limited by statute to the cost of the various services. Not only is it important to know the over-all costs of operating an institution but the information must be available by individual departments rendering specific services.

3. Anticipating expenditures for budget making purposes is the third goal to be served by progressive accounting practices. To improve budgeting through the use of accurate information, classifications of accounts must be objective in their use and terminology so that definite trends in increasing or decreasing costs will be available for the budgeting of funds for subsequent periods. There is a definite need on the part of administration to attempt to forecast revenues and expenditures. This is true not only in the hospital field but in the fields of finance and industry. The public hospital, operating as it does against a definite budget, is particularly interested in correctly forecasting both revenue and a cost of operations for succeeding periods.

4. The fourth goal is in the field of public relations. Adequate accounting practices permit better reporting to the public, administrative boards, legislative bodies and interested agencies. Voluntary hospitals are interested in comparing their operating costs with those of institutions furnishing a comparable quality of service. Oftentimes, voluntary hospitals are members of a group of affiliated institutions. Public institutions are constantly compared with other institutions of a similar type in the matter of operating costs.

If any comparison is to be obtained from accounting records, there must necessarily be some uniformity in classification of accounts. Much has already been done along this line, but there is still opportunity for improvement.

Financial statements on current operating costs too often merely show the amount of expenditures in the various individual expense accounts. This type of statement will show the costs or expenditures for the month and possibly the year to date. If the institution is operating on a budget, undoubtedly the factor of unexpended funds will also be shown. It can readily be realized that merely reporting such totals to the head of an institution gives him little or no opportunity to analyze the factors entering into the cost.

Total Expenditures Alone Useless

A few years ago in a meeting with the superintendent of one of our institutions this very point aroused considerable discussion. He declared that if no more detail than the total expenditures in each account is furnished, the monthly statement is next to useless to him. It is obvious that it would be extremely difficult, under manual methods, to inform the various departments as to the specific items of expense in any one month. This is particularly true in an organization such as we have at Milwaukee County Institutions.

Our organization consists of eight operating institutions or departments and 10 service or overhead departments. With this number of departments employing approximately 1900 employes and providing for a daily average of 6000 patients and others given custodial care, one can readily realize the number of individual items of expense in a particular period.

We realized that some mechanical method of furnishing detailed information was necessary. To facilitate the routine handling of approximately 10,000 transactions each month, we inaugurated the use of tabulating cards as an integral part of our accounting system, starting at the point

Presented at the Wisconsin Hospital Association meeting, 1946.

at which the individual institutions and departments requisitioned materials, supplies and services for their use.

By volume handling of individual transactions through mechanical means, a medium was developed by which the administrator can analyze by object the items of cost that are recorded under fairly general functional headings in operating statements; unit costs are provided to guide the various departments within an institution in their requests for supplies; expense account titles become familiar to department heads in terms of crockery, food, cooking utensils, drugs and the many other items that are included in their day to day operations.

A tabulating card, prepared for each transaction, permits instructions for the movement of goods or for the performance of services and provides a medium for acknowledgments of receipt of such goods or services. The completed transaction has resulted in an exchange of physical properties which now must be recorded so that the cost of this exchange can be properly allocated.

By mechanical means, the unit price is extended by the total quantity and the cost is distributed to the receiving department in summary form and in detail, the corresponding credits going to the department from which the goods or services were originally requisitioned.

Must Know Cost of Each Item

The need for detail to support operating statements prepared under fairly general headings is obvious. Medical services, just to use one general term, are comprised of many items ranging from salaries to linens. The administrator should be in a position to know currently what those things are and what they cost.

To digress for a moment, the detailed listings of all department activities are used in making special studies of operating efficiency and account analyses. We have learned to depend upon these listings for speedy reference.

While we realize that the tabulating system which we use and which we believe to be practical because of our volume may be prohibitive in cost or size to a single hospital, there are other means by which the same objective can be attained. Mechanical equipment is available that will facilitate volume handling of accounting transactions on a smaller scale. This principle can be applied to the presentation of detailed information to various departments in any hospital regardless of size. The pressure of war needs, with its resultant shortage of personnel, has undoubtedly developed mechanical means far beyond those available in the prewar period.

One of the greatest problems in any accounting system is to submit the information to the operating departments soon enough to be of any value and in complete enough form so that a fairly accurate picture of operating cost is presented, including interdepartment and overhead services. Either in a small hospital or in a large group of institutions such as we have, this is a real problem.

In any organization, the costs of operating the service or overhead departments must be completely distributed to and absorbed by the operating institutions. All of these costs directly influence the rates to be charged for hospital services rendered. In some departments, we find that it is desirable to compute the actual costs of the services furnished to the operating institutions. In other overhead departments, this has been found to be impracticable and, as an alternative method, standard costs are used.

A good example of the use of standard costs is in the distribution of laundry charges from the central laundry servicing all institutions and departments. Through a special study, we have arrived at standard costs for every type of laundry service rendered. At the laundry department office, a set of tabulating cards is prepared stating, by garment or item description and process, the services rendered to each institution or department. The worker in this office accumulates the quantity of the various items laundered. The totals for each item are entered on individual tabulating cards, are automatically extended and become the basis of the laundry charge for the month.

In certain of the service departments, it will be found to be impracticable to develop standard costs. In these cases, of which general office expense is an example, it is generally advisable to pro-rate the costs directly in a ratio of personnel costs, total operating costs or some other equitable basis.

Sometimes a combination of various methods may lend itself to greater accuracy. As an example, in our central garage we use the direct cost method on assigned vehicles, which means the total operating costs plus garage overhead of the vehicle so assigned. On unassigned vehicles, a standard cost per hour is used.

It is extremely important that each institution be apprised of its share of the costs of the various services furnished to it. Unless the basis is clear to the administrator, the costs themselves will have little value. The administrator should know the costs of these services currently. In the majority of cases, the amount of charges against a particular institution is in direct proportion to the amount of service the administrator has requested. Not until he receives the charges for this service can he know or can he control the future charges.

We previously mentioned that the accumulation of material relative to costs and expenditures for the various institutions presents a problem in time. Certain basic information as to the extent of services rendered must be available promptly to the accounting department. In an organization such as ours where the service departments are relatively widely separated, many emergencies arise that delay the prompt forwarding of vital information. Lack of personnel, sickness and many other reasons contribute to such delays.

"Trouble Shooter" Speeds Service

To counteract these delays, we have set up the post of trouble shooter. Although a member of the accounting department, the incumbent may be assigned temporarily to any spot in the entire organization. He may assist for several days in the garage, or he may be transferred to the housekeeping department in the hospital to help distribute the costs in this division or he may be assigned to any special task.

The responsibility of the accounting department extends beyond mere accumulation and checking of costs. Activity studies should constantly be made. We are vitally interested in determining whether our services are costing more than similar services from other sources.

Our power plant should be able to produce heat and power at the same or at a lower cost than they could be purchased from local utility com-

panies. Our laundry services should be just as efficient and as economical as the services of commercial laundries. The hourly cost and the mileage cost of our cars and trucks should compare favorably with those of companies furnishing that type of service.

Specialized and stand-by emergency services, such as ambulance services, should be segregated and the cost thereof should be carefully scrutinized. Our electrical department should furnish service as efficiently as electrical repair companies. All of these activities must be continuously checked.

Such changes as our recent salary and reclassification ordinance result in a complete change in the basic cost of every service. This means a review of all standard costs and a reevaluation of all methods of overhead distribution so that administrators can understand the effect of such basic changes in terms of service and material costs. It is not enough to accumulate costs. The costs must be studied to determine the reason for any sharp increases.

The studies are a necessary responsibility of the administrator of every hospital. An adequate accounting procedure can definitely help in the discharge of that responsibility.

Special studies may include historical information relating to costs of operations. In the superintendent's or administrator's annual report, the financial operating statement plays an important rôle. It is not sufficient merely to show the results of the year's operation from a financial angle; these costs should be compared with prior periods to determine cost variations. In addition, there should be some explanation of the influences that cause the variations in cost. For example, price and wage control directives, rationing, priorities, federal training programs and subsidies may be short-lived but they help to explain fluctuations.

The accumulation of statistics also lends itself to the normal functions of an accounting department. At Milwaukee County Institutions, progress has already been made toward the centralization of statistical report preparation in the accounting department. We are using the same mechanical equipment in the accumulation of statistics that we do in the large volume handling of financial data. We hope to relieve medical record clerks of much of the tedious task of tabulating statistics manually. We are presently studying the problem of tabulating medical diagnoses and treatment at our tuberculosis sanatorium. We hope to make that study exhaustive to the end that we may have readily accessible information for future research.

Here, again, our methods and approach may appear to be out of the sphere of the voluntary hospital. The important point, however, is not the type of equipment we use to obtain certain results but rather the fact that facilities are available which would enable even the smallest hospital to do the same type of job.

The increasing demand for financial information and the expanding need for accurate comparative statistics resulting from federal and state participation in local problems of public health place an increasing burden on the shoulders of the hospital administrator. Development of mechanical means, training of personnel and centralization of activities are partial answers to the problem of meeting the added load economically. Hospital accounting must keep pace with the new responsibilities that confront all hospitals in the growing recognition that the health of the individuals in the community is a public responsibility.

VOLUNTEER ACTIVITIES

Mother's Day Next

Anticipate holidays in the hospital gift shop and feature items that tie in with the spirit of the occasion. The Auxiliary Shop at Evanston Hospital, Evanston, Ill., does this and also makes a feature of wedding and birthday gifts. For example, for St. Patrick's Day the hostesses brought forth from the stockroom some fiddle-shaped green glass ashtrays. They made mention of them in the February house organ so that readers could note them on their shopping lists.

Born of an Emergency

For sixteen years of its twenty year existence the women's auxiliary of Huntington Memorial Hospital, Pasadena, Calif., has grown and prospered under the same leader, Mrs. Frederick J. Mills, the present president. This active group can be depended upon in an emergency, as well as for regular support, for it was born of an emergency.

On New Year's Day of 1926 there was a grandstand disaster in Pasadena and a number of women banded together to give aid to the victims of the crash. That group is the present women's auxiliary of Huntington Memorial, which recently has attractively decorated and furnished two bedrooms in the new addition to the nurses' residence.

Major services of this active auxiliary include the financing of blood transfusions, part or full hospitalization, anesthetics and special nurses, when essential, for the needy patients.

The auxiliary provides scholarships for nurses, has furnished the board room and administrator's office and maintains the south garden where patients may be wheeled out in their beds to bask in the sunlight.

Salute to Tumor Clinic

While on the subject of Huntington Memorial, one must give a snappy salute to the Tumor Clinic Auxiliary. This clinic meets every Friday and 26 members of the auxiliary assist in the department. The volunteers are divided into two shifts under a chairman, Mrs. Norman Johnson, and a co-chairman, Mrs. David Pohlman.

The Tumor Clinic, since its founding in 1933, has had 3012 patients and of this number only 617 malignancies have been discovered. Showing a large increase annually, the clinic last year served 510 members of the community.

On March 26, the Tumor Clinic Auxiliary presented a program at the Pasadena Civic Auditorium featuring Paul Draper and Larry Adler. The house, thanks to the benefit committee and its splendid publicity, was sold out with a gross of $6000. The net was $5000.

Those who attended the concert were handed 48 page souvenir programs in which the women had sold advertising that netted the auxiliary $900. Considerable reading matter was sandwiched in among the advertisements so that the merchants were assured a good display.

In addition to background copy on Draper and Adler, space was given to the local Red Cross program, the local volunteer placement bureau and the national cancer control program; officers, committees and patrons of the benefit were listed, and the work of the Tumor Clinic was described.

It All Centers on the Children

developing a comprehensive medical service for children of Michigan's Upper Peninsula

MOSES COOPERSTOCK, M.D.

Pediatrician-in-Charge
Northern Michigan Children's Clinic
Marquette, Mich.

WITH ALL the thought and concern that are being exercised today over the problems of distribution of adequate medical services, particularly as they pertain to underprivileged, thinly settled sections of the country, it seems timely to describe the development of a children's center for medical services in a large remote area of Michigan.

Lacking the highly organized facilities that usually exist in metropolitan districts, a demonstration of the effective pooling and coordination of various available resources to provide a comprehensive medical service to children in such an area may offer a contribution in the search for successful methods of providing up-to-date medical services for similar regions elsewhere.

Early in its broad program for the improvement of child welfare in the state, the officials of the Children's Fund of Michigan, founded 17 years ago by the generous bequest of the late Senator James Couzens, in surveying the health needs of the children of Michigan, recognized in the inadequacy of medical care in the hinterland areas both a great need and an opportunity to raise the level of medical care of its needy children. That section of Michigan known as the Upper Peninsula, primarily because of its remoteness and relative isolation, appeared to be in greatest need.

This large area, the northernmost part of the state, comprises practically a geographic unit in itself by virtue of its separation from the rest of Michigan by the Straits of Mackinac and Lake Michigan. It measures about 350 miles wide and contains a population of approximately 300,000. The chief industries are devoted to ore and copper mining, the latter industry showing evidence of diminishing productivity in recent years. Lumbering, once a prominent activity, has already reached a low point.

It is true that under the state's afflicted and crippled children's acts, expert medical care for indigent children of this remote area is available at the University Hospital at Ann Arbor, but this entails transporting patients at considerable expense over distances varying from approximately 300 to 700 miles. Paradoxically, the most convenient route to Ann Arbor for patients residing in the western part of the Upper Peninsula is by train through Wisconsin and Illinois. In many instances of acute illness, children, of course, cannot be moved such distances.

A modern children's medical unit centrally located in the Upper Peninsula, it was perceived, might afford a twofold usefulness by providing care for indigent children locally and at the same time effecting a considerable economic saving to the state. It became apparent that such a center would also provide an opportunity for the creation of an educational

KEY TO HOSPITAL GROUP

1—Northern Michigan Children's Clinic (out-patient services and administration)

2—James Couzens Memorial (adult in-patient services)

3—St. Luke's Hospital (children's in-patient services)

4—Wallace Nurses' Home

5—Heating and Laundry Plant

6—Children's Cardiac Convalescent Cottage

focal point for the medical practitioners in the area.

In fact, this idea was early advanced by Dr. James D. Bruce, the director of the department of postgraduate medicine of the University of Michigan Medical School, whose active interest was engaged in the development of the project. From this educational point of view, in particular, a cooperative endeavor between the Children's Fund of Michigan and the department of postgraduate medicine seemed valuable and highly desirable.

With the broad objectives fairly well in mind, the next step was the selection of a site for the proposed children's center. Marquette, a town of 16,000 people, the geographic hub of the Upper Peninsula and its largest city, was chosen. A careful analysis indicated that the construction of an adequate, independent children's hospital was not warranted. It appeared that the objectives could best be achieved if such a children's unit could be constructed as an adjunct to a local hospital. In this way, nursing service and laboratory facilities of the established hospital could be employed.

Here, again, an opportunity for cooperative planning and effort presented itself. The outcome was the construction in 1931 of the Northern Michigan Children's Clinic, a three story building on the grounds of St. Luke's Hospital, with the enthusiastic support of the medical profession and the public-spirited lay board of trustees of the hospital.

The clinic building provides two small wards, with six beds each, an out-patient department, administrative offices, an auditorium, a playroom and a dining room for parents and children. The clinic building was connected to the hospital by an enclosed passageway, thereby making the clinic and hospital easily accessible to each other. A separate building was also constructed to serve as a combination heating plant and laundry for both the clinic and hospital buildings.

Representing the university medical school's contribution to this cooperative endeavor, a pediatrician holding faculty rank was appointed to provide professional pediatric care and to promote the educational aims of the program. His appointment was on a full-time basis, his salary being subsidized by the Children's Fund of Michigan. In addition, pediatric intern service was supplied at regular intervals from the department of pediatrics of the University Hospital.

For its part, St. Luke's Hospital made important improvements in its nursing and laboratory services to meet with the demands of up-to-date diagnostic procedure and treatment of childhood conditions. The clinic and hospital were both approved by the Michigan Crippled Children Commission for admission of indigent patients on the same basis as they are admitted to the University Hospital.

In the early stages of its development, the medical facilities were available only for care of children with pediatric conditions, but it became apparent before long that provisions for the care of orthopedic cases would be necessary. Expert local care for children with orthopedic conditions presented the same advantages as for children with medical conditions. Three years after its establishment, a trained orthopedic specialist was added to the service as an accredited member of the group of orthopedic surgeons serving the needs of crippled children in the state under the auspices of the Crippled Children Commission.

This additional service, of course, called for further additions in the hospital personnel and facilities. As a result, a trained physical therapist, a brace maker, an occupational ther-

The playroom is stocked with toys for the entertainment of the patients.

apist and a full-time teacher were appointed and improvements in the physical equipment of the hospital were made, including the construction of a therapeutic pool and the purchase of a variety of modern orthopedic equipment.

Acute surgical conditions were referred to qualified members of the hospital's surgical staff on a rotation basis. Children needing attention for eye, ear, nose and throat conditions were referred to members of the staff who specialized in these fields. Provisions in the crippled children's acts permitted reimbursement for such services as these hospital staff members provided. Children with conditions requiring care of a highly specialized nature were referred to the University Hospital. Thus, in due time it became possible to care for the great majority of children with childhood afflictions who were referred to the clinic.

An increasing need for beds with the growth of the children's services threatened to dispossess the adult population in the hospital and created a need for additional room. Ultimately, this resulted in the erection of a modern building for the care of adult patients to the cost of which the Children's Fund of Michigan contributed in a large measure.

This unit was named the James Couzens Memorial Hospital. The original St. Luke's Hospital building now, in fact, became a children's unit. Concomitantly, the growth of the nursing service demanded adequate living quarters and, fortunately, through a generous bequest funds became available for the construction of the Wallace Nurses' Home.

Within the fifteen years of its existence, the services of this children's center have broadened in several directions. From an educational point of view, the clinic center has afforded a central point for the conduct of periodic programs in postgraduate medicine in which members of the faculty of the university medical school contributed greatly. A highly personalized relationship between the clinic staff and the practitioners in the area has developed through direct consultative medical service, field clinics and scientific talks before local county medical societies, thus providing considerable educational activity of both a direct and indirect nature.

Further expansion of services to children included in recent years the establishment at the center in Marquette of a child guidance clinic under the sponsorship of the State Hospital Commission and the development of a rheumatic fever program conducted in cooperation with the Crippled Children Commission and supported by funds administered by the U. S. Children's Bureau under the Social Security Act. The child guidance personnel is made up of a child psychiatrist (not yet appointed), a psychologist, a medical social worker and a clerk.

Many children with behavior difficulties have already been treated. Preventive aspects of mental illness are receiving particular emphasis in this program and an attempt is being made to treat children with maladjustment problems as early as possible in their development in an attempt to forestall difficulties of a more fixed and deep-rooted nature.

The rheumatc fever program is an intensive effort limited to seven adjacent counties with the center of activities at the children's clinic. It is in the nature of a demonstration program, a local expression of the present increasing nationwide interest in the control of this dread disease in children. This program is likewise conducted on a unit basis, made up of the clinic medical director, a medical social worker, a nursing consultant and a clerk.

As an outgrowth of the work of the children's center, a summer camp was established 12 years ago at Big Bay, a scenic spot 30 miles north of Marquette, where children with a variety of physical handicaps, such as malnutrition, heart disease, diabetes, speech defects and various orthopedic conditions, are cared for under ideal conditions of group education and recreation.

With the experiences of the children's center in Marquette as a background, the officials of the Children's Fund of Michigan felt it desirable and worth while to establish another center in a comparable area in the Lower Peninsula at Traverse City (the Central Michigan Children's Clinic). This followed five years after the founding of the parent institution and its development and progress have been along the same general lines as those experienced at the clinic at Marquette.

I am indebted to M. K. Reynolds, member of the board of trustees of St. Luke's Hospital, for supplying the photographs.

The Foot in the Door

"MY DOOR is always open; I shall be glad to see you any time." Some of us consider this a worthy attitude for any hospital executive to take. Fortunately, all of our staff members do not take us seriously when we make such a generous offer. Perhaps they know better, do not need to take advantage of it or are too busy themselves to hasten the solution of a problem by cooperative effort. As a rule, it is a perfectly safe offer to make, since it puts the onus on the other fellow if anything goes wrong.

However, as everybody knows, there are times when the executive's office door must be closed, because if it is permitted to be opened the least bit, the thin edge of the wedge may be inserted with results that are incalculable in time and energy. Not every interview is constructive. We must be on guard against the chap who rashly promises our guardian-secretary that he will take "only a minute" of our time for there is no such thing as a one minute interview and, if there were, it would have to be condemned as unfriendly, inefficient, inconclusive and administratively tantalizing.

Time set aside for interviews, like other items in the hospital calendar, must be budgeted and apportioned in such a manner as to do the greatest good for the greatest number of our patients. In the executive offices an appointment system is vital. A tactful secretary is an essential pay-roll item if the executive's time is to be wisely budgeted. We take great pains to prevent waste of food, supplies and money and yet waste of time and energy, in too many cases, is not often enough given a second thought. —JOHN F. CRANE, *assistant director, Montefiore Hospital, New York City.*

The impact of war on the Treatment of the Tuberculous in New Jersey sanatoriums

EMIL J. FRANKEL

Director, Division of Statistics and Research
State Department of Institutions and Agencies, Trenton, N. J.

DURING the eventful war years filled to overflowing with unusual social and economic problems, the New Jersey tuberculosis sanatoriums stretched their efforts to the utmost to maintain the high standard of operation which has for years characterized their service as one of the important instruments in the fight against tuberculosis.

Difficulties in the day by day operation of the sanatoriums did not deter them from rendering their best services to the patients entrusted to their care. They struggled valiantly to overcome the problems caused by rising prices for necessities and the application of the priority and rationing system; the rapid increase in salaries and wages in war industries and their influence upon sanatorium personnel and administration, and the continued diminution of the medical and nursing staffs.

A review of the trends under war conditions in the type of patients admitted and their diagnosis on admission, the age groupings in males and females, the length of stay at time of discharge and the relation of sanatorium care to case reporting and tuberculosis mortality should thus be of interest.

Cover Period From 1939 to 1945

The following figures, illustrating these various trends, cover the years 1939 to 1945 and are compiled consistently on the basis of the uniform statistical reporting system developed by the New Jersey Department of Institutions and Agencies.

The basic figures on the adult patient population and first admissions to New Jersey sanatoriums show that in the seven year span between 1939 and 1945 the male population in tuberculosis sanatoriums declined 20 per cent and the female population, 27 per cent. First admissions of males which rose somewhat in the early war years show a marked decrease between 1943 and 1945. The adult female first admissions, however, show a gradual decline from year to year throughout the seven year period (table 1).

TABLE 1 — Adult Patient Population and First Admissions

Year	Number in Institution at End of Year		First Admissions During Year*	
	Male	Female	Male	Female
1945	1299	946	1170	795
1944	1395	971	1348	847
1943	1581	965	1555	886
1942	1713	1133	1482	956
1941	1615	1213	1375	960
1940	1637	1273	1351	994
1939	1617	1298	1356	1061

*Patients who have never before been in a tuberculosis sanatorium.

TABLE 2 — Race of First Admissions

Year	Number		Per Cent	
	White	Negro	White	Negro
1945	1619	346	82.4	17.6
1944	1812	383	82.6	17.4
1943	2011	430	82.4	17.6
1942	1996	442	81.9	18.1
1941	1942	393	83.2	16.8
1940	1964	381	83.8	16.2
1939	2053	364	84.9	15.1

TABLE 3 — Increased Use of Sanatoriums

Year	Tuberculosis Cases Reported to State Health Department	Sanatorium Admissions of Tuberculous Patients (Total)	
		Number	Per Cent
1944	3475	2569	73.9
1943	3868	2854	73.8
1942	3932	2919	74.2
1941	3559	2802	78.7
1940	3702	2795	75.5
1939	3665	2896	79.0
1938	4148	2826	66.5
1937	4285	2935	68.5

Sanatorium administrators agree that the reduction in the number of patients is to be largely ascribed to the unusual employment opportunities available during the war years which caused many patients to leave the sanatorium even against the advice of the physician.

Race of First Admissions. The greater need for sanatorium care of Negro patients, as evidenced by their high case and mortality rate, is met in an increasing measure by the enlarged number of admissions of Negro sufferers from tuberculosis to the various sanatoriums (table 2).

TABLE 4 —Diagnoses of Male and Female First Admissions

Year	Adult MALE First Admissions			Adult FEMALE First Admissions		
	Per Cent Diagnosed as			Per Cent Diagnosed as		
	Pulmonary Tuberculosis	Other Forms of Tuberculosis	No Tuberculosis	Pulmonary Tuberculosis	Other Forms of Tuberculosis	No Tuberculosis
1945	84.2	2.7	13.1	87.9	3.5	8.6
1944	82.1	2.6	15.3	85.9	2.2	11.9
1943	86.2	2.1	11.7	86.6	2.2	11.2
1942	84.9	3.0	12.1	89.4	2.2	8.4
1941	84.2	2.9	12.9	88.3	3.9	7.8
1940	86.5	1.7	11.8	87.9	3.1	9.0
1939	84.8	2.7	12.5	89.6	1.4	9.0

While the number of first admissions of white patients has shown a marked decrease in the seven year period, there has been only a slight net decrease in the first admissions of adult Negro patients.

Case Reporting and Sanatorium Admissions. The record shows that an increasing proportion of tuberculosis cases officially reported to the state department of health found their way into tuberculosis sanatoriums for restorative care (table 3).

The increased use of tuberculosis sanatoriums no doubt reflects successful educational efforts in enlarging the general case-finding activities and increased public consciousness of the value of sanatorium treatment both as a curative procedure and as a preventive measure.

The noticeable increase in the number of tuberculosis cases reported to the state health department in 1942 and 1943 as against 1940 and 1941 was due, first, to the cases of tuberculosis found in selective service registrants at the time of the induction examination who had not previously been known to suffer from tuberculosis or had not previously been reported, and, second, to the extended industrial hygiene program under which a large proportion of industrial employes were given chest x-ray examinations.

Medical Type of Patients Admitted. In the case of all first admissions, both males and females, to tuberculosis sanatoriums, more than 85 per cent were diagnosed as suffering from pulmonary tuberculosis. An increasing proportion was diagnosed as not having tuberculosis (table 4).

The following reasons have been assigned for the growing number of nontuberculous patients entering tuberculosis sanatoriums: (1) Cases of bronchiectasis, lung abscesses and other chest conditions can receive more appropriate care in a modernly equipped sanatorium than in a general hospital; they may be cases admitted and retained because there is no other public institution to which they can be transferred. (2) More cases are being admitted for complete diagnostic study that is not possible in the office of a private physician or a clinic. (3) Some communities may not have sufficiently accurate diagnostic facilities to screen out cases which should not be accepted for admission to sanatoriums.

TABLE 5—Diagnosis of Pulmonary Tuberculosis

Year	Per Cent of Pulmonary Tuberculosis First Admissions Diagnosed		
	Minimal	Moderately Advanced	Far Advanced
1945	12.8	27.4	59.8
1944	13.7	27.1	59.2
1943	13.3	27.8	58.9
1942	11.4	29.9	58.7
1941	10.8	30.3	58.9
1940	11.2	27.6	61.2
1939	10.3	30.3	59.4

Diagnosis of Pulmonary Tuberculosis in First Admissions. The general tendency toward an increasing proportion of pulmonary tuberculosis patients entering the sanatoriums in the minimal stages of the disease reflects a desirable trend from the standpoint of tuberculosis control (table 5).

Age Factor in Pulmonary Tuberculosis in First Admissions. The age distribution in male and female first admissions is strikingly different. The proportion of females under 20 years is more than twice that of the males of the same age group. Practically the same situation obtains in the age group 20 to 34. It is in the age group 35 to 49 that the male admissions are proportionally the highest and considerably above that of the females. The proportion of male admissions over 50 years of age is virtually three times that of females over 50 (table 6).

Death Reporting and Sanatorium Deaths. The trend toward an increase in the proportion of sufferers from tuberculosis who die in a sanatorium continued during the war years, with the exception of 1944 when a slight proportional decrease occurred (table 7).

The attitude of the sanatorium, the patient and the relatives is largely responsible for this generally desirable tendency. It recognizes the importance of not keeping moribund patients in the home to die but to have them enter a sanatorium so as to give them such active medical care and succor as is possible. This segregation of highly infectious cases is in accord with the best practices in tuberculosis control.

Length of Sanatorium Stay. It is to be expected that the length of sanatorium stay has a direct relation to the successful restoration of the patient's health. The figures in table 8 show this clearly and indicate also an increasing average length of stay all along the line, when comparing the present situation with that obtaining some ten years ago.

The length of stay of patients before discharge from tuberculosis sanatoriums did not change materially during the early war years but ex-

perienced a pronounced reduction in 1944 and again in 1945 (table 9).

The sanatoriums are conscious of the importance of educational work on the patient before admission and during his hospitalization to make him recognize the value of prolonged care and the danger to himself and his family of a return home while he is still in the infectious stage.

Collapse Therapy Activities. The extent of activities in the field of collapse therapy over the period 1940-1943 is given in table 10 and covers 14 New Jersey tuberculosis institutions. These figures are based upon the reports gathered painstakingly by G. J. Drolet, consulting statistician of the Tuberculosis Sanatorium Conference of Metropolitan New York.

The types of operative procedures applied to obtain collapse and the changes in the number of patients in whom these procedures have been applied over the four years are shown in table 11 (see next page).

Enhances Danger of Infection

Against Doctor's Advice. Considerable concern has been expressed over the fact that a sizable proportion of patients leave tuberculosis sanatoriums in normal times without the consent of the physician and that this tendency was accentuated in war time, particularly because of the more ample employment opportunities in the community. Sanatorium men and all others in the tuberculosis field deeply regret this interruption in the beneficial treatment afforded the patient and the dangers of infection that the returning patients present to their families and to the community.

The problems thus created were given careful consideration in a review conducted under the auspices of the New Jersey Tuberculosis League a year or so ago. There was a considerable body of opinion that advocated the employment of legai means, for the protection of the com-

TABLE 6 —Age Distribution in Male and Female Patients

Sex and Age	Per Cent of Pulmonary First Admissions in Age Groups						
	1945	1944	1943	1942	1941	1940	1939
Under 20 Years							
Male	5.6	5.6	7.4	6.6	7.4	6.8	7.2
Female	15.0	15.5	16.0	16.9	18.0	17.2	17.2
20 to 34 Years							
Male	18.4	27.0	28.6	32.7	31.7	32.1	33.2
Female	50.5	52.1	54.2	51.6	54.1	54.6	53.8
35 to 49 Years							
Male	35.8	34.0	34.8	30.2	29.8	30.7	30.3
Female	20.6	21.5	18.5	19.9	20.0	15.4	18.8
50 Years and Over							
Male	40.2	33.4	29.2	30.5	31.1	30.4	29.3
Female	13.9	10.9	11.3	11.6	7.9	12.8	10.2

TABLE 7 —Sanatorium Deaths

Year	Per Cent Tuberculosis Deaths in Sanatoriums of Total Deaths Reported to State Department of Health
1944	51.3
1943	56.9
1942	49.9
1941	49.1
1940	50.8
1939	49.9

TABLE 8 —Relation Between Length of Stay and Condition on Discharge

Condition on Discharge	Average (Median) Days of Sanatorium Stay	
	1941–1943	1929–1931
Arrested	367	267
Apparently Arrested	373	240
Quiescent	296	234
Improved	214	129
Unimproved	98	75

TABLE 9 —Average Length of Stay Before Discharge

Year	Average (Median) Days of Sanatorium Stay of Patients Discharged Alive and Admitted as			
	Pulmonary Patients	Minimal	Moderately Advanced	Far Advanced
1945	201	141	255	198
1944	210	177	230	213
1943	232	173	232	262
1942	228	174	236	242
1941	236	147	238	266
1940	233	160	242	255
1939	226	151	233	249

TABLE 10 —Collapse Therapy Activities in 14 Hospitals

	1943	1942	1941	1940
Patients Under Collapse Therapy at End of Year	781	947	1178	1269
Average Number Receiving "Repeats" During Year	695	835	929	930
Patients Having Had Any Form of Collapse Therapy First Time During Period	1271	1357	1591	1910

TABLE 11 — Types of Operative Procedures

Collapse Therapy (In-Patients)	1943	1942	1941	1940
Pneumothorax				
Successful Initial	798	1,002	1,197	1,583
Failures	148	140		
Refills	38,178	47,206	53,572	55,762
Aspirations	1,842	1,758	*	*
Thoracoplasties	269	370	308	351
Phrenic Operations	45	47	60	109
Pneumonolyses	265	317	*	*
Pneumo-Peritoneums	107	158	*	*
Oleothoraces	139	118	*	*

*Not reported separately.

munity, either to restrain patients from leaving the sanatorium or to obtain commitments. Others were more inclined toward the application of education and persuasion in dealing with more recalcitrant patients.

There seems to be general agreement that the factors which are at the root of the individual's troubles need to be carefully gone into and that all available methods must be employed to remedy them as far as possible. It is felt that it is incumbent upon us to consider each patient as an individual. The solution of the patient's problems should be based on the case work principle. It is desirable that this procedure be carried through by a specialized worker in close collaboration with the physician, the nurse, the clinic and the sanatorium.

In an article by Jean and Leo Behrman published in the *Family* in April 1944 regarding "The Signing Out of Tuberculosis Patients," great confidence is placed in the medical social worker who is attached to the sanatorium to help the patient utilize the medical care necessary for recovery and to assist the patient to acept a physical limitation. "The individuality of every situation is marked, and therein lies the challenge to the social worker. By knowing the sick person and his reactions and by a helping relationship, the social worker can assist the patient and community toward a goal of health."

Cooperative Attitude Urged

In their stimulating treatise on "Occupational Therapy in the Treatment of the Tuberculous Patient," published in 1944 by the National Tuberculosis Association, New York City, Holland Hudson and Marjorie Fish make this significant observation in regard to the length of stay of sanatorium patients:

"In the operation of a general hospital, rapid turnover of patients may correlate with medical and administrative efficiency. In the treatment of tuberculosis, almost the reverse may be true. In tuberculosis we are dealing with a chronic and a reactivating type of disease, which may be controlled and healed only by protracted treatment. The hospital staff must combat the natural irritation of the patient group at so prolonged and so trying a requirement. Every therapist in tuberculosis work needs to understand the impulse of patients toward voluntary discharge against medical advice and the importance of continued patient cooperation to successful medical result."

Life Is Real — Life Is Earnest

AFTER excellent training by "Professor" Grimaldi and having been formally presented to the "Chase" family, we were supposed to be ready for duty. I recall the trepidation with which I undertook my first enema, of course, under the supervision of Mrs. Grimaldi. The victim restored my poise considerably by murmuring, "I'll do anything you say, Doc." Apparently all went well; the patient survived and so did I.

On my way through the second floor corridor one day I was called into one of the private rooms where a gray-haired woman lay ill. I asked what I could do for her. "Will you turn on the water over there and let it run? I've got an idea." I complied and hurried away.

When the grandson of the Bishop of Long Island was a few hours old I happened to be on duty and was asked to fill his incubator with ice. Thus, I had the distinction of being the Bishop's grandson's first iceman.

One day, I was attending an Italian boy who had just returned from the O.R. He wanted to tell me about his operation and I listened. "You know, that Doc's got the same racket I have, only I'm drilling concrete."

The perfect model of modesty was discovered when I started to "prep" a man whose bed was near a window facing north. He insisted on having the shade down because there was an apartment house "not a block away."

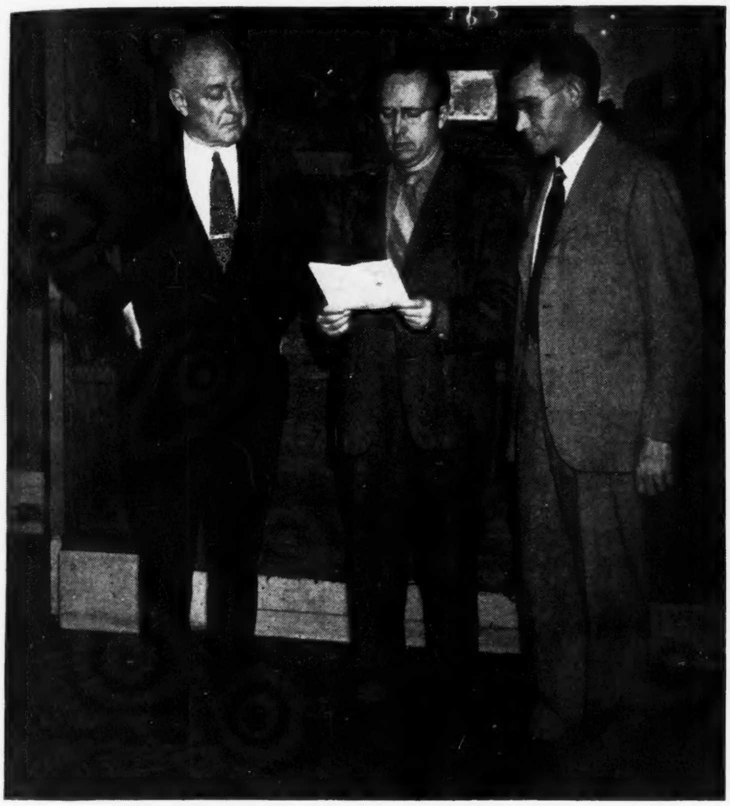
Occasionally, my duties took me to "G," and one day I was helping with a 6 year old lad. A "Wangensteen" had been ordered and two nurses and an intern were trying to hold the struggling boy. Finally, after restraints had been applied to his ankles and wrists, the kid looked at me helplessly and said: "Well, it's three to one!"

I had suspected that nurses take the troubles of their patients in a matter-of-course manner and become pretty hard-boiled about suffering and death. But one day when one of the swellest fellows I ever met died—it had been my privilege to do many things for him—and there were tears in the eyes of the nurse as she told me about it, I changed my mind.

I could tell more stories but conclude by saying that our work has been very interesting. There were times when I was the only assistance the floor nurse had. The nurses have been wonderful and have given us the feeling that we are working with them, not for them. The patients, too, have been appreciative, pathetically so at times. All in all, it has been a privilege to give a hand at Nassau Hospital; it has been an education for us and, we hope, a contribution to the hospital.—WINFIELD A. TOWNSEND.

*Reprinted by permission from The Fluoroscope, Nassau Hospital, Mineola, N. Y.

PEOPLE IN PICTURES



ABOVE: Philip C. Staples, vice president of Associated Hospital Service of Philadelphia and president of the Pennsylvania Bell Telephone Company, examines the new contract offered to subscribers of the Philadelphia Blue Cross with E. A. van Steenwyk, plan director, and Rufus Rorem, director of the Hospital Service Plan Commission.

BELOW: Lawrence Payne, administrator of Baylor University Hospital, Dallas, making a presentation to Everett W. Jones, vice president of The Modern Hospital Publishing Company, and James A. Hamilton, hospital consultant, at the Texas meeting in Dallas, March 21 to 23.

ABOVE: Dr. Winford H. Smith, who retired April 1 as director of Johns Hopkins Hospital after thirty-five years of service, bids farewell to his successor, Dr. Edwin L. Crosby Jr., who was assistant director for six years prior to receiving his new appointment.

BELOW: John R. Mannix, Chicago Blue Cross plan director, greeting former governor John W. Bricker of Ohio at the Blue Cross meeting, Cincinnati, March 25-27.

FIGURE 1—ST. LOUIS CITY HOSPITAL
REPORT TO THE MEDICAL DIRECTOR

The following interns served on the ______________________

Service from ______________________ to ______________________ and

were rated as indicated:

E (Excellent)	A (Average)
VG (Very Good)	F (Fair)
G (Good)	P (Poor)

	Personality	Ability	Performance

Signed ______________________
Attending Physician

FIGURE 2—SAMPLE OF HOUSE OFFICER RECORD

Jones, John P., A.B., M.D.
Intern 7/1/42 to 7/1/43

Date	Service	Personality	Ability	Performance	
7/1-7/24	Medicine	VG	G	P	10
7/24-8/16	Medicine	VG	G	P	10
8/16-9/8	Pediatrics	VG	VG	A	13
9/8-10/1	Pediatrics	VG	VG	A	13
		20	18	8	46 or 3.8
	Average	VG (5)	G (4.4)	F (2)	11.5 or 3.8
10/1-10/24	Surgery	VG	VG	G	14
10/24-11/16	Surgery	VG	VG	G	14
11/16-12/9	Fractures	VG	VG	G	14
12/9-1/1	Urology	VG	VG	G	14
	Average	20	20	16	56 or 4.7
		VG (5)	VG (5)	G (4)	14 or 4.7
1/1-1/24	Psychiatry	VG	VG	VG	15
1/24-2/16	Psychiatry	VG	VG	VG	15
2/16-3/11	Out-Patient	VG	VG	VG	15
3/11-4/1	Receiving Room	VG	VG	VG	15
		20	20	20	60 or 5.0
	Average	VG (5)	VG (5)	VG (5)	15 or 5.0
	Average for year	60	58	44	162 or 4.5
		VG (5.0)	G– (4.8)	A– (3.7)	G– or 4.5

Total grade point average G– or 4.5
Rank 30 in 58

An Objective Rating

LEO J. WADE, M.D.

Assistant Professor of Medicine
and Preventive Medicine
Washington University
St. Louis

ALL hospitals engaged in training programs for house officers are beset by queries from medical schools, hospitals, employment agencies, boards of licensure and boards of certification concerning the caliber of work done by house officers.

As a rule, only general evaluations are offered in lieu of specific data. While this leaves much to be desired on the part of the inquirer, it is moderately satisfactory to the hospital administrator so long as he is able to give a "good" report.

Qualms of conscience, however, usually annoy the administrator who tries to conceal the fact, or who openly admits, that a man was an unsatisfactory house officer. Such qualms are well justified unless the rating is something more than an impression. In all fairness to the house officer, the rating should be based on objective evidence, and some clues as to the nature of the man's shortcomings should be available.

Last of all, the man himself should have been aware of his shortcomings and have had some opportunity to correct whatever defects there were. The response or lack thereof to criticism is invaluable in any accurate rating of the individual.

Almost everyone will agree with the desirability of carrying out such a program, but the feasibility of doing so in a large institution, such as St. Louis City Hospital, might well be questioned. We have devised a scheme which has worked to the almost complete satisfaction of the intern and the administration alike. We believe this system has served the further purpose of keeping house officers alert and on the job. Inquiries from neighboring institutions have led us to believe that the scheme may be of some general interest.

Method of House Officers

MILDRED ANDERSON STOCK

Both the internship and residency have been divided into 12 equal periods (one month under the annual appointment system and approximately twenty-three days under the 9-9-9 program). At the end of each period, the superior of each house officer (residents and/or visiting physicians) is presented with a form (fig. 1) on which are recorded the names of interns and residents assigned to his service. Space is provided for the rating of the house officer on the basis of three factors: personality, ability and performance.

A separate rating is requested on each of these and the ratings are recorded as:

Excellent	(6)
Very good	(5)
Good	(4)
Average	(3)
Fair	(2)
Poor	(1)

Upon return of this blank, the numerical equivalents (see right-hand column above) are added and averaged to give a grade point average. Obviously, the best possible average is 6.0; the worst possible, 1.0. Running averages may be kept, but we have made such averages only at the end of each four periods (fig. 2). At such times, the intern is handed a slip on which are recorded his grade point average and his rank (fig. 3). It is his privilege to inquire concerning the particular services or the particular factors on which he did badly.

This scheme may not be a potent influence for improvement of the general caliber of work done by the house staff unless some objectives are provided. Here at City Hospital we have refrained from making any commitments with regard to service assignments for more than one trimester. Subsequent assignments are made on the basis of rank; the man with the highest grade has first choice, while the man with the lowest grade takes what remains.

FIGURE 3—NOTIFICATION TO HOUSE OFFICERS

Dr. ____________________

Your work, during the past three months, was such as to result in a grade point average of________out of a possible 6.0. You rank________ in your section and________in the entire group of interns. You will receive a call to report to this office to choose your rotation of services for the next three months. Please respond promptly.

Medical Director

On more than one occasion, we have seen brilliant improvements in men after the first period. There is little possibility of changing the intern's innate ability, but added effort in getting on with patients and confreres, plus hard work in routine matters of patient care, can more than compensate for mediocre ability.

If records are kept in the manner described, one is in an enviable position for furnishing information concerning any house officer. The number of grades assures an objective and fair evaluation of the individual's work. Whether he is good or bad, one can be specific about the aspects that made him a good or bad house officer. As indicated before, response to criticism is often invaluable in determining the desirability of a man for appointment in a large organization. The system described permits accurate evaluation of this response.

A Prayer of Appreciation

ALMIGHTY and everlasting God, before whom stand the spirits of the living and the dead, Light of light, Fountain of wisdom and goodness, who livest in all pure and humble and gracious souls:

For all who have witnessed a good confession for thy greater glory and the welfare of our fellow citizens in the founding, the growth and the maintenance of this hospital.

WE RETURN THANKS UNTO THEE O GOD, AND BLESS THY HOLY NAME:

For the many thousands who have entered this hospital and have found it to be a veritable house of healing;

For all trustees who through many years have conscientiously served the best interests of this hospital;

For the superintendents of the hospital who with patience, courage and skill faced day by day their exacting duties;

For all physicians and surgeons who have brought skill of the highest order for the healing of bodies, minds and spirits;

For all nurses who with trained skill have given of their very best for the accomplishment of the hospital's chief objective;

For all administrative and technological associates and all others, however indirect, who are engaged in the work and care of the hospital;

For the advance in scientific knowledge and for the perfecting of technics with respect to healing;

For the organization of the Guild which has proved of enormous value to the hospital and which has offered to thousands of women eagerly accepted opportunity to participate personally in sacrificial service;

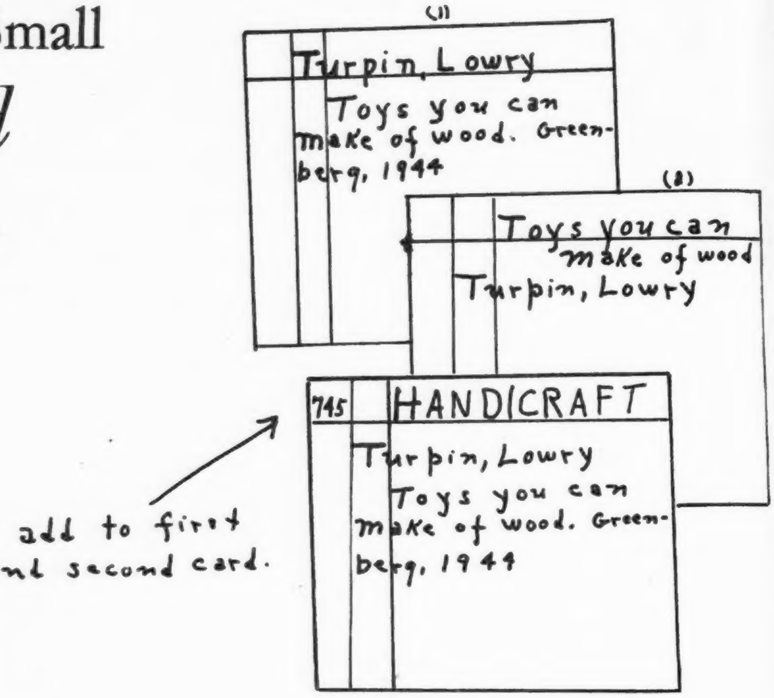
For the exalted truth spoken by the Nazarene that it is more blessed to serve than to be served and that our minds and hearts are firmly committed to this idea;

For the inner assurance that this hospital was inspired by the Great Physician and that His guiding hand will continue to lead us into an enlarging field of gracious helpfulness.
—BISHOP TITUS LOWE, *Indiana Area, The Methodist Church.*

No Library Is Too Small *to Be Cataloged*

KATHARINE E. MUFF

Librarian
Station Hospital
Camp Chaffee, Ark.



WHEN making plans for cataloging a few hundred books, one finds that the rules given for simple cataloging for small libraries are too complicated, since most writers consider a library of several thousand volumes small.

Many ingenious systems have been devised for the truly small collections. All have one fault in addition to lack of standardization: the successful library grows, and outgrows, the makeshift system. Then records and, worse, marking on books must be done over again. Yet to catalog according to good usage takes more time than can easily be spared from other duties and results are unnecessarily detailed as long as the library is in its infancy. To postpone cataloging at all quickly leads to confusion.

As a possible remedy, I suggest the following procedure which divides the cataloging process into four stages. The librarian may stop, indefinitely, at the completion of each stage until use indicates further needs.

I

1. Check books with invoice as received and stamp with mark of ownership on reverse of title page and on lower margin of last page of text.
2. Keep full accession records from first acquisition. Buy a standard loose-leaf accession book from a library supply firm.
3. Write accession number in the book just below the property stamp.
4. Type book cards giving author, title and accession number. Place in pockets pasted on the inside back cover of books. Have a simple system of charging books. The borrower's name and ward or room number usually are sufficient information. Arrange cards by wards or sections. Expand or modify circulation records as needed.
5. Prepare a shelf-list card for each book showing author, title, publisher and copyright date. Arrange cards alphabetically and use as an author index until catalog is made. Shelve books in any convenient order.

II

When the library has about 500 books of all classes, start an author-title catalog. Use form of first two examples shown. File cards in one alphabetical file.

III

1. When 200 books of nonfiction have been received, separate fiction from nonfiction, if you have not already done so. No further cataloging is necessary for fiction. The form you have used suffices for all but large libraries. Arrange books of fiction alphabetically by author's surname and, separating the shelf-list cards from those for nonfiction, alphabetize them also.
2. Sort nonfiction into general works (dictionaries, encyclopedias); philosophy and psychology; religion; social sciences; language study; pure science and mathematics; useful arts; fine arts and amusements; literature (other than fiction); history; travel, and biography. These groups are similar to the main divisions of the Dewey decimal system of classification which you may later use. Label sections of shelves.
3. Write the subject, *i.e.* "history," clearly but *in pencil* in the upper corner of the inside front cover of the book and on the shelf-list and catalog cards. Arrange the shelf list in the same order as the books.

IV

Not until you have 20 or more books in each group, need you begin to complete the cataloging process. In fact, if the library is understaffed, you may postpone it much longer.

I know of one very satisfactory high school library, supervised by an overworked teacher-librarian, that has operated successfully for years at this stage. The librarian wisely expended what time and energy she had toward building up her collection of books and getting her pupils acquainted with them.

When you start, you will need as authorities and working tools three books: Dewey: "Abridged Decimal Classification," Forest Press, $2.50; Akers: "Simple Library Cataloging," American Library Association, $1.50, and Sears: "Subject Headings for Small Libraries," H. W. Wilson, $2.75.

If your cataloging training is limited, now is the time to request the help or advice of a trained cataloger. Since you have done the preliminary work, she can accomplish much in a few hours.

1. Assign subject headings and classification numbers to nonfiction. If you are certain that the nonfiction section of your library will never be large, do not classify beyond the decimal point. If yours is a growing library, do not oversimplify classification.

In either case, subject headings should be used liberally; the smaller the library the more fully its resources must be utilized.

You need only add your classification number to the author and title cards made previously, erasing the penciled notation, make your subject cards, following the same form (example 3) and add the classification number and "tracing" to the shelf list. Return author and title cards to the alphabetical file, file the new subject cards in the same file and file the shelf-list cards in numerical order.

2. If you have not previously done so, shellac the spines of all books to be marked. This is also good protection for the fiction. Write the classification symbols in uniform position with white ink of good quality. When dry, shellac them again. In case of error, changes can be made without damaging bindings.

3. Arrange books by the classification number.

Lady With a Lamp and a Purpose

AS HOSPITALS observe the 125th birthday of Florence Nightingale by the now traditional practice of holding open house or otherwise inviting public attention to the hospital's accomplishments in the community, it is unlikely that many people remember much of anything about Florence Nightingale except that she was the nurse who took care of the soldiers during the Crimean War—and became famous for it. Most nurses will remember also that she later founded the Nightingale Home at St. Thomas's Hospital in London, thus establishing the pattern for our modern hospital training schools.

While these achievements alone are sufficient to make the continuing celebration of her birth by hospitals appropriate, there is much more about Miss Nightingale's life that is worth knowing and thinking about. Her whole character, in fact, exemplified qualities that we look for and honor in men and women doing public welfare work. She was personally modest and unassuming, yet with a deep compassion which gave her courage to act swiftly and boldly where aid for the suffering was concerned.

It is commonly thought, for example, that she was called to her work in the Crimea when it became known that sick and wounded soldiers there were dying from neglect and filth. Actually, the nursing expeditionary force was her own idea. She went to the secretary of war with her proposal and, when her offer was accepted, she organized the expedition herself, using methods that would do credit to a Hollywood press agent.

At that time, Miss Nightingale had for some years been the leading hospital expert of her day, the prototype of today's highly skilled and knowledgeable hospital consultants. Like most of them, she came by her knowledge the hard way. As a young girl, she went down to London from her parents' home in Hampshire for the social season every year, then spent the season investigating conditions in hospitals, nursing homes, reformatories and other charitable institutions.

Practically as soon as she was old enough to travel by herself, she was off on a tour of inspection of European institutions. She spent months at a time working and observing in the best hospitals on the Continent, her interests ranging from the actual technics of nursing to the organization of food and supply services and the layout of wards.

According to the most reliable historical sources, the classic picture of Florence Nightingale, lamp in hand, working on the wards in army hospitals in the Crimea is an accurate one. She arrived on the peninsula just as British forces were finishing a sustained effort to drive Russian field batteries from the heights at Balaklava, near Sevastopol, a campaign which included the heroic but disastrous "Charge of the Light Brigade." The strategic position of the troops at the moment was favorable, but supplies were badly disorganized, the casualty rate had been terriffic and cholera was everywhere.

Her unflagging devotion to the needs of individual soldiers made her an inspiring leader of nurses, but Miss Nightingale was first of all an organizer. With 10,000 sick and wounded British soldiers in field and base hospitals under her care, she took over the gigantic task of cleaning up and establishing organization and supply lines which would get food and drugs and bandages and workers where they were needed—on time.

Miss Nightingale cut hard across red tape, brushing aside military and political dignitaries who protested that "it had always been done this way." Skilled in the uses of public opinion, she played on her popularity at home to get the results she wanted—and got them. The death rate among British troops at the end of the war was one twentieth of what it had been when she took over.

Enthusiasm for her work soared in England; a man-of-war was ordered out to bring her home, and a great public reception was prepared in her honor. With her war work done, however, Florence Nightingale was not one to stand around taking bows. She sneaked in undetected on a French ship and was back at work in her hospital before news of her homecoming got out. As it is to the best leaders in the health fields today, publicity to her was something to work with, not just to savor. The Nightingale Home was founded with funds raised by public subscription as a memorial to her services in the Crimea.

Hospitals which are using National Hospital Day as an occasion for educating the community in the work they are doing—so that the work can be done more effectively—would have the full approval of Florence Nightingale. That was her method.

SMALL HOSPITAL FORUM

They *Will* Visit the Sick

EVERY hospital administrator knows that visitors frequently worry or tire sick patients and thus delay recovery, and that they also interfere with hospital routines and make it harder to get necessary work done. On the other hand, many patients benefit from visits with relatives and friends and, certainly, when no conflict with the patient's medical needs is involved, it is not the hospital's place to bar visitors indiscriminately.

Restricted visiting hours are the compromise that has been developed over the years in response to these various demands and pressures. Like many compromises, this one is only partly successful. Exactly half of 30 hospitals replying to a Small Hospital Forum on this subject report that they have difficulty making their rules for visitors "stick."

The commonest reason given for allowing exceptions is the fact that visitors often come from a considerable distance, traveling at the mercy of random train or bus schedules and arriving inopportunely just as visiting hours are over. Under these circumstances, many administrators report, it seems unnecessarily harsh to turn them away when the restriction is imposed for convenience only.

Sometimes, it is acknowledged, the hospital's good nature in these matters is abused. "They always seem to have excuses for visiting out of hours," one administrator reports; "either conflict with working hours, or coming from out of town or something else." On the whole, however, people accept the rules and abide by them, once they understand that restrictions are necessary for the well-being of all the patients.

Visiting hours in the small hospitals participating in this forum are fairly well standardized. An hour and a half or two hours in the afternoon and a similar period in the evening are the common arrangements; about half of these hospitals also permit visiting for an hour or so in the forenoon. In 25 per cent

Unless you try everlastingly to make them more understanding, visitors are going to gum up the works and upset the patients in your hospital

of the hospitals, additional visiting privileges are accorded to patients in private rooms; in most of these cases visitors are permitted at any time from 9:30 or 10 a.m. to 8:30 or 9 p.m. In two hospitals, Sunday visiting hours are a little more restricted than weekday hours.

Nineteen of the hospitals replying to the forum do not differentiate in visting hours between obstetric patients and others; eight hospitals report shorter hours in the obstetric department. About the same hosppitals differentiate between obstetric and other patients in the number of visitors permitted. Half the hospitals reporting do not attempt to restrict the number of visitors at any time. The prevailing rule in the other hospitals is two visitors at a time, although in one or two cases the number allowed is three.

Nine hospitals do not have any special rules for child visitors. The others will not permit children under a stated age to visit. The age limits given range from 12 up to 16 years; the average of the ages stated is 13.2. In two or three cases the restriction on child visitors applies only in the obstetric department. One hospital allows only the patient's own children as visitors.

An interesting response resulted from the question: "Do you ever permit visitors (other than qualified professional visitors, that is) in the operating room? The delivery room? Under what circumstances?"

Twenty-one hospitals answered with an unqualified "No!" The other 10 acknowledged that there were some circumstances under which such visiting was permitted—of course, with the consent of the operating surgeon or obstetrician.

Statements accompanying the replies indicate that this practice is permitted by some hospitals when the surgeon himself requests it, or sometimes in the case of a critically ill child whose parents wish to be present, or when the husband or mother

of an obstetric patient wants to see the baby delivered, or otherwise "on rare occasions" or "for some very special reasons." Apparently, even those hospitals that permit visitors in the operating rooms are aware that the practice needs justification.

The majority view is expressed by one administrator who replied: "No, no—for this we make no exceptions! We consider it a dangerous and uncalled-for practice which is unfavorable to the best interests of the patient. Neither anesthetist nor surgeon feels free to discuss the condition of the patient when nonprofessional persons are present."

Less than half the hospitals have cards or folders setting forth and explaining the visiting regulations. Those that do have these for distribution to patients and their families say that this helps to promote understanding and observance of the stated rules.

One of the best of the folders submitted with replies to the forum is the one used by Thayer Hospital, Waterville, Maine. A few of the lively illustrations and brief, compelling messages contained in this folder are shown in the samples reproduced here. In addition to these hints about the number of visitors, the length of the visit, flowers and smoking in the hospital, the folder covers such subjects as use of radios in patients' rooms, noise in hospital rooms and corridors, guest trays and other pertinent facts that people unfamiliar with hospital routines are likely to overlook.

THANKS TO THESE CORRESPONDENTS

HOSPITAL	RESPONDENT	BEDS
Marcus J. Lawrence Memorial Hospital, Cottonwood, Ariz.	Martha Leyel, R.N.	24
Cody Hospital, Cody, Wyo.	Tresa S. Worrall, R.N.	25
Coeur d'Alene Hospital, Coeur d'Alene, Ida.	Alexander Barclay, M.D.	28
Sweetwater Hospital, Sweetwater, Tenn.	M. F. Henley	28
Park City Miners Hospital, Park City, Utah		30
Thayer Hospital, Waterville, Maine	Pearl R. Fisher, R.N.	35
Neepawa General Hospital, Neepawa, Man.	Olive G. Dennison	40
Women's Hospital, Flint, Mich.	Margaret E. McLaren, R.N.	40
La Crosse Hospital, La Crosse, Wis.	Martha B. Horn	44
Newton Memorial Hospital, Newton, N. J.	Bessie M. Roy	50
Albert Pike Hospital, McAlester, Okla.	J. O. Wilburn	55
Brightlook Hospital, St. Johnsbury, Vt.	Mrs. Eva L. Morris	55
Michael Meagher Memorial Hospital, Texarkana, Ark.	Sr. M. Baptista	55
Fairview Hospital, Great Barrington, Mass.	Elizabeth I. Hansen	63
Wheatley-Provident Hospital, Kansas City, Mo.	L. M. Tillman, M.D.	67
Lawrence Memorial Hospital, Lawrence, Kan.	Mrs. Mary G. Dunden	67
Litchfield County Hospital, Winsted, Conn.	Austin J. Shoneke	68
Florida Parishes Charity Hospital, Independence, La.	James S. Andrews	70
Humboldt Co. General Hospital, Winnemucca, Nev.	Bertha Morton	70
St. Mary's Hospital, North Platte, Neb.		70
St. Anthony's Hospital, Wenatchee, Wash.	Sr. M. de Lourdes	75
Wabash Employes Hospital, Decatur, Ill.	Neva Bridgman	75
Central of Georgia Railway Hospital, Savannah, Ga.	C. F. Holton	76
Marion Sims Memorial Hospital, Lancaster, S. C.	Katharine O. Altman, R.N.	76
Carlisle Hospital, Carlisle, Pa.	Viola M. Green, R.N.	77
George Washington University Hospital, Washington, D. C.	L. G. Schmelzer	90
Methodist Hospital, Pikeville, Ky.	Thos. B. Ashley	90
Mary Imogene Bassett Hospital, Cooperstown, N. Y.	Hilda B. Tyler	95
Parkview Hospital, Pueblo, Colo.	Mrs. Helen K. Pixley	96
Marion General Hospital, Marion, Ind.	J. Howard Johnson	100

"Each visitor does something to promote or retard the patient's progress," the introduction to this attractive piece states. "It's impossible to fix rules that will best fit every case, so we solicit your own thoughtful aid." That the folder has brought about the results it seeks to accomplish is demonstrated in the comments of Pearl R. Fisher, administrator at Thayer Hospital.

"As a rule, we find most visitors patient, considerate and appreciative of the fact that they are permitted to visit," she states. "We try to be as lenient as possible, although, of course, we do not permit visitors to interfere in any way with the care of the patient."

In contrast, some administrators find visitors a continuing bothersome problem. "The general public does not comprehend the importance of hospital routines," says one who admits that visitors' rules are not successfully enforced in her hospital.

"The public will not cooperate unless it's made to do so," is another comment. "We make the rules stick but often under considerable protesting. It takes a lot of policing." Describing the problem in a small town where business men like to visit their sick wives and children before going to work in the morning, the superintendent of a southern hospital says: "Public relations suffer more from enforcement of visiting hours than from any other reason; therefore, we are lenient, except where contagion is concerned. However, we do know that unrestricted visiting causes confusion and hampers both nurses and physicians."

Another administrator puts the period to the whole discussion of visiting hours with the eloquence of simple earnestness: "Visitors are our greatest problem," he declares.

About People

Administrators

Dr. Harold C. Lueth has been appointed dean of the college of medicine, superintendent of the University Hospital and professor of medicine at the University of Nebraska, Chancellor C. S. Boucher announced April 15. The appointment will become effective July 1, the announcement said.

Recently released from the Army Medical Corps with the rank of colonel, Doctor Lueth is now practicing medicine in Evanston, Ill. He is associate professor of medicine at the University of Illinois Medical School in Chicago and consulting physician for the Veterans Administration hospital at Hines.

Doctor Lueth holds five degrees from Northwestern University, where he was a member of the medical faculty from 1930 to 1936. He then taught at the University of Illinois until he entered the Army in 1940. His Army service included assignments as chief of medical service at Fort Sheridan Station Hospital, liaison officer to the American Medical Association for the surgeon general, and chief of the classifications branch for the surgeon general's office in Washington.

Doctor Lueth is a diplomate of the American Board of Internal Medicine and the author of several books and numerous professional articles in his field.

Charles Lee, for the last thirteen years director of East Orange General Hospital, East Orange, N. J., and president of the New Jersey Hospital Association, has resigned effective June 30. Mr. Lee is a fellow of the American College of Hospital Administrators.

Joseph Friedheim, formerly administrative intern at St. Luke's Hospital, New York City, has been named assistant to **Dr. Edwin L. Crosby,** whose appointment as medical director of Johns Hopkins Hospital was recently announced in these columns.

Burton H. Morrell, who recently resigned as administrator of Princeton Hospital, Princeton, N. J., has become superintendent of Fairview Hospital, Great Barrington, Mass.

Forst R. Ostrander has resigned as superintendent of Pawating Hospital, Niles, Mich.

Henry A. Hooper, lieutenant colonel in the U. S. Infantry, has returned to Cincinnati General Hospital, Cincinnati, as administrator.

Mrs. Calista Fulkerson, R.N., is the new superintendent of Douglas County Hospital, Omaha, Neb., according to **Phillip F. Vogt,** county welfare administrator. Mrs. Fulkerson has been supervisor of isolation and polio service at the institution for the last year, and her promotion fills a vacancy which has existed for the last two years. Prior to going to Omaha, she served as assistant supervisor of Denver General Hospital, Denver, from 1937 to 1945. Mrs. Fulkerson will have jurisdiction over medical service, and Mr. Vogt will continue in charge of business and financial activities of the hospital.

Ray E. Brown, assistant superintendent of the University of Chicago Clinics, has been appointed to succeed **Dr. G. Otis Whitecotton** as superintendent, it was announced April 23. Mr. Brown, who was first appointed to the hospital staff in September 1945, was superintendent and professor of hospital administration of the North Carolina Baptist Hospital, Bowman School of Medicine, Winston-Salem, N. C., from 1943 to 1945. He holds a master's degree in hospital administration from the University of Chicago.

John L. Brown, auditor at Samaritan Hospital, Troy, N. Y., prior to entering Army service, has returned to the hospital as assistant superintendent. **Warren Bovie,** who replaced Mr. Brown during the war, is remaining on the staff.

Hubert Hutt, ensign in the U. S. Navy and recently released after several years' service, has leased Community Hospital, Lexington, Neb. He has appointed as superintendent of nurses, **Marie T. Bode,** R. N., former assistant to **Lucinda Jennings** who plans to take an extended rest before resuming nursing activities. Mr. Hutt has purchased a large residence in Lexington as a nurses' home, the first step in providing accommodations for the nursing personnel of the institution.

Paul Hanson, formerly administrator of Iowa Lutheran Hospital, Des Moines, has been separated from the Army after four years' service and has returned to his post at Iowa Lutheran. He held the rank of captain in the Medical Administrative Corps.

Orville Peterson is the new administrator at Copley Hospital, Aurora, Ill. Recently discharged from the M.A.C., Mr. Peterson is a former administrator of Eldora Memorial Hospital, Eldora, Iowa.

Dr. Eugene L. Sielke, superintendent of Danville State Hospital, Danville, Pa., has resigned to accept the superintendency of Philadelphia State Hospital. As fifth superintendent at Danville, Doctor Sielke served from May 1, 1943, to Feb. 28, 1946. He was assistant superintendent at Philadelphia prior to directing the Danville institution. **Dr. Vincent J. Cassone,** formerly director of clinical psychiatry and associated with Danville State Hospital since 1935, has been named acting superintendent and **Dr. Howard T. Fiedler,** formerly a lieutenant colonel in the Army, is assistant superintendent.

Alice E. Snyder has been appointed administrator of Geneva Hospital at Geneva, N.Y. Prior to her appointment Miss Snyder was acting administrator of St. Luke's Hospital, Marquette, Mich.

Thomas Henley, recently released from the Army, has been named business manager of the Bishop Clarkson Hospital, Omaha, Neb.

John Kauffman has been appointed administrator of Princeton Hospital, Princeton, N. J. For the last eight years Mr. Kauffman has been at the Reading Hospital, Reading, Pa., where he served successively as clerk, cashier, admitting officer and assistant administrator.

Department Heads

Lt. Ira L. Ernst, U.S.N.R., on duty with the Navy since 1942 and released to inactive duty on March 30, has been

(*Continued on Page* 170)

Hospitals Can Help the Aged

J. R. McGIBONY, M.D.

Senior Surgeon
Hospital Facilities Section
States Relations Division
U. S. Public Health Service

WITH tongue in cheek that prince of medical practitioners, Sir William Osler, in a farewell address at Johns Hopkins set the medical and public press of the early 1900's into prolonged debate by giving at least partial approbation to the tenets of a novel of the period. This controversial plot hinged upon the idea of a college into which men retired at 60 for a year of contemplation before a peaceful departure by chloroform.

The tempest created was almost bewildering to the kindly Osler, for he himself was approaching that age and could not but have known that he was at the zenith of a career which was to leave an unparalleled impression upon medicine in general.

Problems Are Multiplying

That the problems of older age groups are multiplying today by leaps and bounds is easily discernible from the increasing attention being given to geriatrics by physicians, by cursory examination of census figures, by reflection upon politically potent groups of oldsters, which more or less stampeded action through "Townsend Clubs" and similar organizations, and by the attempts at solution of the problem by adoption of various state and federal systems of social security.

With a static or decreasing birth rate and a life expectancy of 70 years an early probability, a rapidly increasing proportion of older people is inevitable. Within this century the majority of the population of America will be more than 50 years old. One in seven will be over 65, while 40 per cent will be more than 45 years old.

Clinical phases of geriatrics can properly be left with those concerned directly with immediate study and treatment of specific conditions. However, the hospital administrator and his entire staff have a responsibility and an opportunity to make a major contribution in the field and at the same time benefit the hospital.

Such opportunities may, and probably will, be presented oftenest during actual hospitalization for some real physical illness or for some manifestation of the multiplicity of mental hygiene problems which only the sympathetic application of principles of psychosomatic medicine can remedy. It is particularly in the latter application that the progressive and understanding hospital staff can play an important part in easing the obstacles of senescence. Such efforts will help thwart the drift of misunderstood, bewildered, sympathy-seeking oldsters into the hands of charlatans and shady institutions.

Mental Integrity the Same

The personality structure and mental integrity of the majority of those of advanced years are fully as capable as younger groups, albeit lacking the briskness. Lack of acceptance of suggestions and new ideas and general nonconformity are traits that are not suddenly acquired upon reaching the age of retirement; in truth the child is father of the man.

A real contribution by the hospital can be the attempt at analysis of the temperamental, often cantankerous, old Mr. (or Mrs.) Grundy who can make life miserable for an overwrought staff, but whose quick recovery and generally improved outlook on life may be largely dependent upon being understood. To prolong life merely to extend the years can be a cruel and heartless thing.

One physician has stated that it is our duty to "preserve not only health and life but joy of living." Prime factors in producing such joy in living are a realization of being needed, of belonging, of ability to contribute, even in small measure, to the activities of the individual's world, however limited in scope. Extensive participation in community affairs is not necessary to evoke such reaction.

During the war the manpower shortage to a large extent postponed for many the stark despair so often faced by those who are relegated to the shelf of retirement or are unable to cope with the rapid-fire cold efficiency of a world which has placed a premium on youth. This postponement makes it imperative to plan for the adjustment of thousands of oldsters equally as much as for returning veterans.

Positive Action Is Needed

Industry and veterans' organizations will go far in solving problems for the latter group. It behooves all in the medical field to take positive action for the others. The time to begin is now. Intelligent approach to the problem will aid the hospital in relieving personnel shortages and will form the basis for a tremendous contribution to gerontology, to psychosomatic medicine, to peace and happiness of those in need and to general stability of the nation.

Psychology of the aged is practically a virgin field and it will test the ingenuity of the hospital administrator and his staff to pioneer in a manner that will produce mutual benefits. It may be approached profitably through existing clubs and organizations, many of which are already cooperating with hospitals, primarily from patriotic motives, but which might be encouraged to continue and extend certain phases of their activities.

There is no subject more intriguing and no interest more consuming than health, and this interest in-

tensifies in almost geometrical ratio with added years. Every effort should be made to encourage continuation of interest among the individuals and groups that contributed as nursing and hospital aides, the Red Cross and other activities of the many religious and philanthropic organizations that served in so many useful ways.

With the receding of the tumultous enthusiasm to serve engendered by war and the glamour of patriotism, interest will rapidly fade, particularly among the younger volunteer workers. Perhaps formation of "Over 60 Clubs" or some similar auxiliary among both men and women in your community would serve to sustain an interest that is highly desirable for successful administration. Concomitantly, it would inject a strong therapeutic factor into the need for being wanted and needed among that age group. Such thoughtfulness will provide untold dividends in good will.

Many Ways They Can Serve

A few of the many ways in which such groups can and will usually gladly serve include: reception of patients and visitors; assisting with records, secretarial work, tray and refreshment service, minor ward, laboratory and dietary work; knitting, sewing and attention to related linen needs and other supplies; preparation of dressings; operation of libraries and canteens; obtaining and distributing reading material or flowers; assisting with various phases of social welfare work; preparation and maintenance of landscaping, flower and vegetable gardens; general dissemination of favorable information to the public, and assisting in and contributing to fund-raising campaigns.

There is little need to enumerate further the many ways these individuals can be used and helped since they are fairly obvious to the alert administrator who is not averse to investing a little time and effort to obtain both real and intangible assets by making a positive contribution to personal happiness and to community welfare.

"It's an owercome sooth fo' age and youth,
"And it brooks wi' nae denial,
"That the dearest friends are the auldest friends,
"And the young are just on trial."
—Robert Louis Stevenson.

They Pool Their Resources *for Community Health*

A partial summary of the activities of Cincinnati hospitals and health and welfare agencies through which the community is educated to better health

ELLEN STANDING

Health Education Secretary, Anti-Tuberculosis League, Cincinnati

"WHAT do you do in the way of health education?" This question, asked of Cincinnati hospitals and clinics, was a tough one. Few communities pool their health education resources so completely as does Cincinnati. Hospitals, clinics and every other health agency are voluntary members of that pool which, more professionally speaking, is called the Public Health Federation.

So asking any of those 50 and more health agencies "What do *you* do?" is like asking "What health education resources do *you* pull out of the pool, combine and enrich with your own agency identities and give out to the community as contributions in the total objective: a better and healthier people?"

Since it is impossible to draw a definite line of distinction between health eduction and service the question is doubly difficult.

The University of Cincinnati's General Hospital, however, as the clinical center for its college of medicine, naturally leads in health programs specifically planned for their educational as well as service values. Again, these activities are so numerous and so integrated into the activities of other community agencies that to present them as isolated projects is misleading, but momentarily the spotlight is centered on a few projects of the out-patient department: the cancer, heart, food, "central" (psychiatric) clinics and the activities of the babies' milk fund.

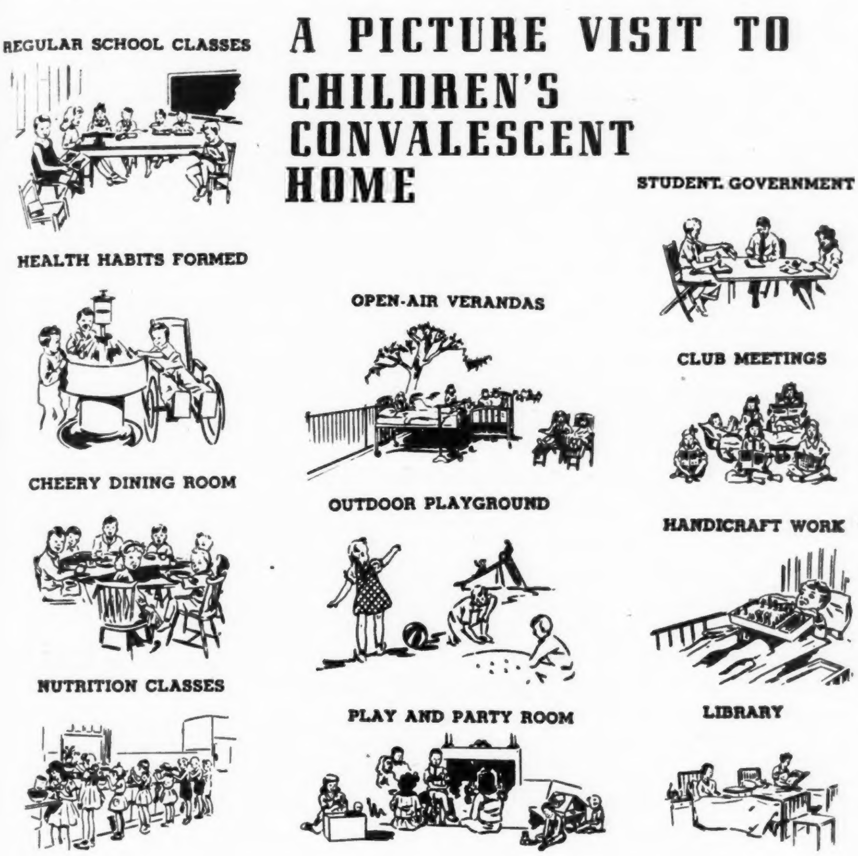
The cancer clinic is staffed through the college of medicine; the school of nursing furnishes nursing personnel; the medical social worker is financed by the cancer council of the Public Health Federation through Community Chest funds; x-ray and laboratory service and space for the clinic are provided by the hospital.

Spreads Helpful Information

While the clinic is planned primarily for the educational benefit of the medical student and the therapeutic benefit of the patient, it is indirectly responsible for spreading helpful knowledge to stimulate people to seek earlier medical advice following first indications of cancer symptoms and for fostering happier mental attitudes.

The heart clinic is operated on much the same basis as the cancer

A PICTURE VISIT TO CHILDREN'S CONVALESCENT HOME



clinic but is divided into two sections: one for adults, the other for children. Individual education and counsel are constantly given to the heart case to teach him the way of life he must adopt in view of his disability. This individual education of the patient on the part of physicians, nurse and medical social worker is considered as an important factor in keeping the ambulant heart patient from becoming a hospital case and, incidentally, saves money for the community tax payers. Important in both groups, this educational service is particularly so for adults.

Follow-Up Service Rendered

The children's heart clinic (the largest proportion of whose patients are victims of rheumatic fever) maintains an intensive health education service in the home. A nurse, financed by the Public Health Federation's heart council through Community Chest funds, visits homes of all children who have registered in the clinic. This service continues until the patient approaches the late teens or early twenties. Family guidance and interpretation are given by the nurse and arrangements are made as occasion indicates for rehabilitation, special training, attendance in special schools, such as the Condon, or other needs.

One young woman who has been under the guidance of the cardiac clinic throughout her school years has now completed high school and is ready to enter a school for laboratory technicians. Inasmuch as there is no such school in Cincinnati, the rehabilitation service will sponsor her work at Western Reserve University.

The General Hospital's "central," or psychiatric, clinic is a joint project of the hospital, college of medicine, Community Chest, juvenile court and child welfare board. The director of the clinic is director of the hospital's psychiatric service and is professor of psychiatry in the medical school.

The clinic functions in the following areas: (1) as the psychiatric ward of General Hospital; (2) in conjunction with postgraduate work of other departments pertaining to medicine and pediatrics; (3) as a school for the graduate training of psychiatrists; (4) undergraduate education for medical students; (5) as the Community Chest psychiatric clinic for children and adults, and (6) in conducting investigations.

The staff conducts lectures and seminars among professional groups, such as doctors and nurses, social workers and psychologists, and among such lay groups as women's clubs, P.-T.A. and nursery teachers, pointing out the value of psychiatry and establishing a better understanding of normal emotional health.

Showing while telling is the method used by nutritionist or physician in the General Hospital's food demonstration clinic. Student nurses, dietitians and nutritionists, medical students, expectant mothers, diabetics, wives and mothers of diabetics and people who suffer from many other nutritional ills attend the demonstrations.

The demonstration table and cupboards are modest in appearance; the sliding doors that hide them when chairs are "turned the other way" for a different type of discussion are inconspicuous, but hundreds of professional and lay persons have a better understanding of "how to do" from having seen as well as heard.

The General Hospital provides office space in its out-patient department for the central headquarters of the Babies' Milk Fund Association. Operating in conjunction with the pediatric department of the medical school, this agency gives an educational service in child care to expectant mothers, young mothers, mothers of premature infants, medical and nursing students and, indirectly, to the community at large.

Home Demonstrations Given

An important part of its educational work includes the individual discussion and demonstration in the home. A maternity nurse interviews each mother before she leaves the hospital; a home visit is made the day following the baby's hospital dismissal and at regular intervals thereafter. The B.M.F.A. conducts prenatal clinics in downtown areas and, prior to the physician's arrival at these clinics, educational classes are held for the expectant mothers. It is planned to expand these classes with the use of educational movies and other visual instruction aids.

Dunham Hospital, which is the county tuberculosis institution, has a daily patient population of approximately 500. Since education and understanding play a particularly important rôle in tuberculosis control and treatment, Dunham Hospital faces a big responsibility in health education. Its program must reach and be adapted to in-patients and their families, patients awaiting admission and their families, discharged patients, potential patients, medical and nursing students and professional and lay community leaders.

Health Education Projects

Health education for in-patients is met largely through personal discussions with physician, nurse, dietitian, social worker and teacher; through planned radio broadcasts; through movies, posters, books, leaflets, bulletins and exhibits; through *Cheerio* (the patients' house organ), and through other programs developed by a convalescent patient committee.

Dunham Hospital is included on the rotating internship service of the college of medicine and its resident interns receive a wide variety of tuberculosis experience.

The nursing department conducts student nurse affiliations with various schools of nursing and arranges postgraduate observation and lecture seminars for public health and other nurses, in addition to resident postgraduate courses as indicated.

The superintendent of Dunham Hospital is a physician who was recently also made tuberculosis controller for the county.

Most unusual, perhaps, of Dunham's many-sided educational program is the work of the tuberculosis coordinators. These physicians, one for adults, the other for children, are staff members of the hospital. They review the clinical situation of all incoming patients before admission and consult with the family physician.

Coordinator Is Clinic Consultant

The children's tuberculosis coordinator is medical director of the hospital's children's ward and is also tuberculosis consultant in the pediatric clinics of the Children's Hospital and Cincinnati General, and in the various clinics of the health department.

All pediatric tuberculosis clinics are restricted in number to allow an adequate educational procedure. Children, most of whom are known tuberculosis contacts, must be accompanied by parent or guardian. The tuberculosis coordinator, the family physician and the parent discuss the medical interpretation. One or more volunteers assist the public health nurse; many times a medical student is present, thus further expanding the clinic's teaching value.

In the conversation it is explained why "contacts," even though they look well, may be infected. Wholesome attitudes are established and fears are allayed. When a child seen in one of the clinics is the first case of tuberculosis discovered in a family, persistent follow-through is made until the adult spreader is discovered.

At times a selected clinic story is sufficiently altered to disguise the identity of the patient and is adapted for practical teaching use in high school classes in health or hygiene subjects.

The tuberculosis coordinators are often called on by physicians to assist in specific problems. For instance, recently a Negro baby died of tuberculous meningitis. The coordinator was requested to help discover the source of infection. Tactful but persistent investigation was made until the open case was discovered, was placed under hospital treatment and is now on the road to recovery.

In innumerable ways Dunham Hospital contributes to the community fight against tuberculosis through spread of wise information.

The diagnostic clinics of the various health departments with their participation in community projects, such as the high school victory corps, social hygiene surveys, P.-T.A. roundups and the Anti-Tuberculosis League's mass chest x-ray programs, contribute an immeasurable service to community health education.

Other clinics, such as Shoemaker serving Negro groups, have an intensive educational program.

The Public Dental Service Society as an outgrowth of its children's clinic conducts a rotating poster exhibit service to all city schools. Exhibits are routinely rotated by means of "pony express."

The Beckman Clinic, serving Jewish families, recently exhibited a "Better Breakfast" in its waiting room.

Each clinic and hospital contributes not through one avenue only but many. St. Mary's, spotlessly clean, genuinely hospitable, surrounded by Cincinnati's poorest, is a constant health exhibit. The street urchin, pointing it out, glows with pride and respect. Health movies are shown to its employes.

The Children's Convalescent Home "where children learn to smile again" is an hour by hour school in health and healthful living. Group educational work with parents was curtailed during the war but will gradually be resumed and expanded.

Childrens' Hospital conducts group discussion meetings with fathers and mothers of current out-patient diabetics.

They All Contribute

Jewish, Good Samaritan, Christ, Bethesda and Deaconess hospitals, through their interns, schools of nursing, dietetic internships, research foundations, social service, occupational therapy, hospital hostess and out-patient departments; through patient or family visits, or via waiting room library, news story, printed leaflet or bulletin board exhibit—all contribute to community health education and each project is a story in itself.

The superintendent of nurses of Our Lady of Mercy Hospital teaches health in a community college.

St. Francis Hospital reflects cheer and peace in a troubled world.

The County Chronic Disease Hospital and Home fluoroscopes the chests of all newcomers and makes further chest x-ray studies when indicated, just to make sure they don't have tuberculosis — and sometimes they do.

Catherine Booth Home and Hospital has arranged for chest x-ray examinations to be made of its patients on admission and again before discharge. A varied program of health movies is scheduled for its patients this year. "The girls stay with us at least six months," said the superintendent, "and we wish to utilize that time in providing them as many educational benefits as can be arranged."

Yes, Cincinnati's hospitals and clinics, no matter how busy, are eager to contribute their part in the building of a healthier and a better world.

TRUSTEE FORUM

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As I See Trustees

A Public Health Commissioner Expresses His Views

VLADO A. GETTING, M.D.

Commissioner, Massachusetts Department of Public Health, Boston

THE personnel of the Massachusetts Department of Public Health has many occasions upon which to meet with the trustees of hospitals. Although most of our contacts have been with hospital administrators and with physicians, nurses and other employes in hospitals, we of the department have felt it important to confer with the trustees of various institutions from time to time.

The hospital standards of the department do not specifically call for a board of trustees. However, it has been our experience that hospitals that are governed by boards are, in the main, better organized and better administered than are those in which the owner, or someone representing the owner, is the sole governing officer.

Served as Ex Officio Trustee

As commissioner of public health of the city of Worcester some years ago, I was ex officio a trustee of Belmont Hospital in that city. This experience as a trustee has served me well in evaluating the services that can be rendered by a board of trustees to a hospital. Now as commissioner of public health of the commonwealth of Massachusetts I am responsible for the administration of five hospitals and sanatoriums under the department's jurisdiction. None of our institutions has a governing body or board of trustees.

It has been the experience of the department that a well-balanced board of trustees can be of great assistance to the hospital. The board should, insofar as is possible, be a cross section of the community in that members represent the various interests. These members should not represent individual organizations but the various professions and thinking in the community.

The individual trustee must be willing to work as a part of a team. His interest in the hospital should not be limited to attendance at regular meetings of the trustees or at meetings of subcommittees but should extend actively into the actual needs of the institution.

Selection of individual members should not be solely upon the basis of representation of all interests but should take into consideration the character, the standing and the capacity of each individual concerned. Quite naturally, each member should be an outstanding success in his particular sphere of activity.

Much has been written about the size of a board of trustees. It is our experience that the larger boards, some of which may contain as many as 40 or 60 members, are not truly boards of trustees but are really public relations committees which oftentimes are not active. In one instance, for example, a board of trustees consisting of some 40 members has a by-law establishing the presence of seven members as a quorum. Obviously, it is not the intent of this institution to have all of the members of the board present at its meetings. We might ask, therefore, to what purpose is such a board designed?

If the objective of a board of trustees is to be that of general policy formation, approval of appointments, the setting of professional standards and the coordination of professional interests of the hospital with the administrative, financial and community responsibilities; if the board of trustees is to have any administrative function whatsoever, then it must be composed of a relatively small number of active and able persons. This number should be nine or less.

If, on the other hand, the board of trustees is not to assume any administrative function but is to act as an advisory group, then it may well consist of a larger number. A compromise may be achieved by having a small board of trustees that would have administrative functions and, in addition, an advisory board on which could be placed individuals who are particularly interested in the welfare and health of the community and in the administration of the hospital.

Small Board Serves Best

In my opinion, it is far better to have a small board whose meetings can be conducted with decorum and dispatch than a large one at whose meetings open discussion is not possible and matters are presented merely for the information, as it were, of the board members.

Unfortunately, we have seen instances in which trustees have been a hindrance to the institution. This hindrance may be of two different types, the first of which is the political trustee. The political trustee is not necessarily one who is a city politician; he may be a church or organization politician. I have in mind individuals of both types who, because they are, in effect, agents of either a certain political machine or an organization, feel that they must work for the ends of the group they represent.

On boards of trustees they have thus interfered with the sound administration of an institution, losing their proper sense of responsibility to the institution and replacing it by their desire to do favors for members of either their political party or their organization. Such trustees can

From a talk presented at the New England Hospital Assembly, Boston, March 1946.

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pry into detailed administrative setups in an institution and not only make a nuisance of themselves but actually be a source of discord and poor morale in the institution. They can further impose upon the hospital superintendent through demands for the employment of relatives, friends or affiliates of their party or organization.

The second type of trustee who can interfere in the sound administration of an institution is the well-meaning person who is profoundly interested in the institution but, because of his lack of understanding of either professional or administrative standards, makes suggestions or what he considers investigations and draws conclusions from these that are erroneous and misleading. Such trustees may, because of the stand they take, cause considerable embarrassment to the administration of the institution.

Ideal Trustee Defined

The ideal trustee is one who, having been properly selected, becomes one of a team concerned with (1) determining the needs of the institution, (2) evaluating the facilities to meet those needs and (3) formulating plans to meet such needs for which facilities may be lacking. Hence, he is a man who is willing to sit with his fellow trustees and discuss with them their views and, if necessary, subordinate his pet theory to the consensus of the group.

The trustee must, in addition, serve as a means of imparting the needs of the community to the hospital administrator and also keep the community informed of the hospital needs and of the work it is accomplishing. In some instances, trustees are appointed because they themselves are a means of financial support to the institution. This procedure should not be recommended, inasmuch as the assistance of such individuals can be procured by placing them upon an advisory committee or some other authorized organization of the hospital. To be sure, trustees are concerned with the proper financing of the institution, but not from their own pockets.

There is no need to discuss the proper functions of a board of trustees. However, I should like to discuss the future of the hospital in relation to public health and the rôle that the trustee must play in the future. When hospitals were first organized in this country about a hundred years ago, they were designed primarily as places to which patients went to die. A patient did not look forward to entering a hospital to derive benefits or to be cured.

Gradually, the hospital, which is the workshop of the physician, has become so improved through advances in the medical sciences that now patients go to hospitals with every expectation of overcoming their illness and returning to their homes as well individuals. The hospital, however, is still primarily an institution for the sick, and although the patient is glad to go to a hospital for medical care, he only goes near its portals if it is absolutely necessary.

The function of a hospital should extend far beyond the care of the sick. The good health of the members of the community is a positive asset and something that must be worked for, and the hospital has its proper responsibility in the public health organization of the community. The hospital should be a place to which people come who are apparently well. Their purpose in coming to the hospital is for the maintenance of good health, the achievement of optimal health. Thus, in designing a new hospital or in rebuilding existing facilities, the board of trustees should consider seriously the desirability of including facilities for the detailed examination of patients who come to the hospital for periodic checkups, *i.e.* well child conferences, cancer prevention clinics and clinics for the aged, who should have periodic examinations.

Methods of mass diagnosis are being developed that will make it possible for a hospital, through the application of a procedure that is neither time-consuming nor expensive, to make a preliminary diagnosis as to whether or not a patient may be afflicted with a specific disease. For example, in Philadelphia methods are being devised for the determination by simple tests as to whether a patient should receive a thorough examination for the possible existence of a cardiovascular disease.

Other examples are the routine x-ray examination of all out-patients and in-patients, the taking of microscopic bloods for blood sugars and vaginal smears for the diagnosis of cancer. As such methods are developed the function of the hospital will be to care for the well and to aid the community's citizens in achieving optimal health.

In planning facilities for health supervision, the trustees must coordinate their plans not only with the particular needs of the institution they serve but also with other agencies in the community, other hospitals, health departments, volunteer health agencies and any other group that serves the public in the general field of public health. It is my sincere hope that the hospital of tomorrow will be more closely coordinated with the official field of public health and that the activities of the local health department and the hospital will prove mutually beneficial as a result of this closer association.

In this future relationship of the hospital and the board of health of tomorrow, the trustee will be called upon to wield an even more important function and will be called upon to a greater extent to assist in the coordination of the activities pertaining to public health in the community. He will be called upon for assistance in planning health supervision not only in his own institution but throughout the community.

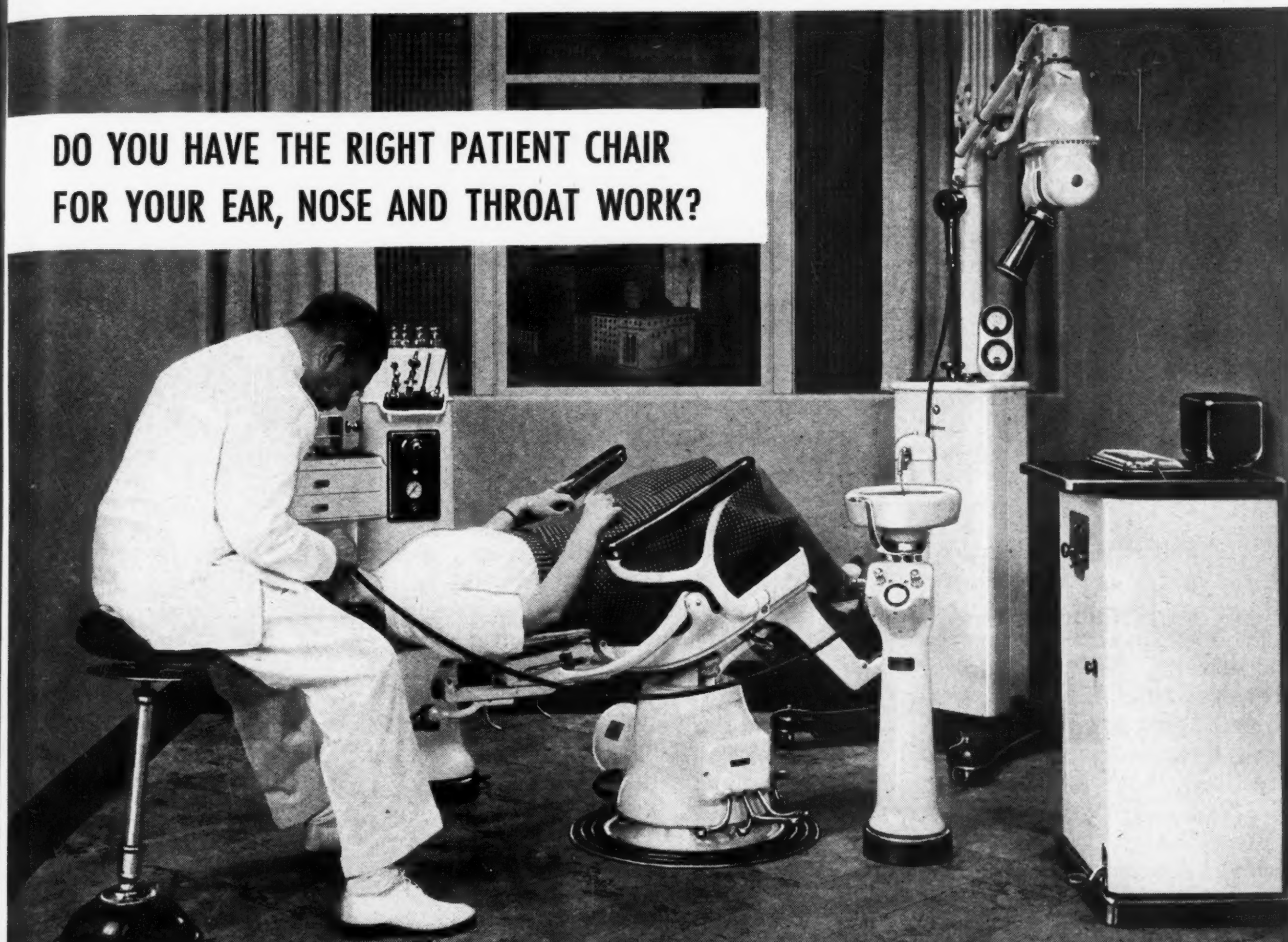
Consequently, the selection of trustees is even more important now than ever before, and we in public health and hospital administration must remember that to hospital trustees both public health and hospitals owe a great debt for the service which these individuals have so willingly and so ably rendered and will render to an even greater extent in the hospital of tomorrow.

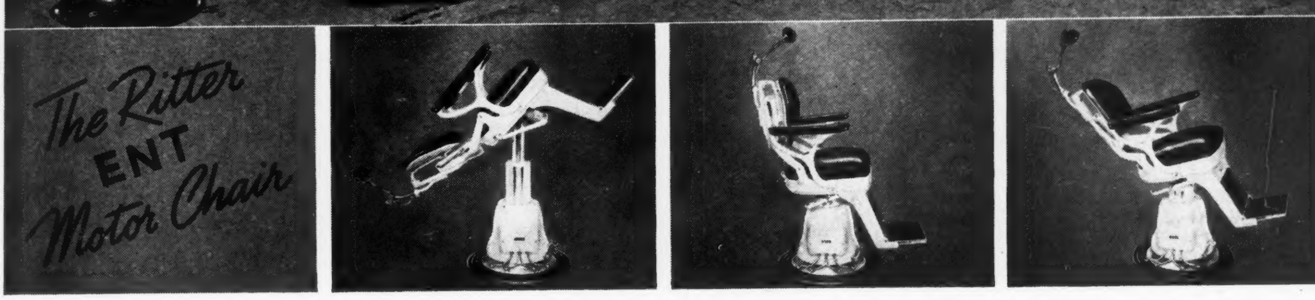
Question of the Month

Question: What legal responsibility rests upon the board of trustees in terminating a doctor's staff membership?—S.T.

Answer: The board of trustees has the legal right to conduct the medical staff in the manner it considers befitting the institution. It should and may appoint physicians to the medical staff, maintain standards and, if the individual physician does not adhere to the accepted standards, terminate or regulate his staff membership.

In this connection one should read Hayt and Hayt "Legal Guide for American Hospitals," pp. 52 to 55, inclusive.





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To Control Air-Borne Infection

T. F. DANFORTH, M.D.
Chief, Laboratories Section

D. M. RUDIG, M.D.
Bacteriologist

W. I. FISHBEIN, M.D.
Epidemiologist

Department of Health, Chicago

THE importance of air-borne infections as a cause of disease is now clearly recognized. Although many different concepts have been held through the ages concerning methods of transmission of disease, the important rôle played by air-borne infections has become well established during the last decade.

In 1933, W. F. Wells, an engineer at the Harvard School of Public Health, described a method of quantitative determination of bacteria in air.[1] The Wells air centrifuge has made possible the accurate evaluation of many methods recommended for the control of air-borne infections. In the studies described in this report it was found to be the most accurate method.

Study Effectiveness of Agents

The present carefully controlled experiments were conducted in order to determine the effectiveness of a mechanical device combined with a chemical solution in destroying bacteria in air. Many investigations have shown that the incidence of air-borne infections can be greatly reduced or controlled by effectively destroying the causative bacteria in dormitories or living quarters.[2,3]

In the past, prevention of air-borne infections has been attempted by three types of agents:

1. The use of mechanical barriers, including the control of air currents, filters, face masks and partitions.
2. The treatment of floors and bed clothes with oil has been reported to decrease infections caused by dust-borne bacteria.
3. The method which has received the greatest approval is destruction of bacteria in the air. The use of filters, barriers or dust-laying oils merely tends to prevent the spread of infection at a specific time and place. It does not remove the cause of infection and, hence, the danger of false security continues to lurk. The distinct advantage of destroying the bacteria themselves is obvious.

Ultraviolet radiation[4-15] has been used with more or less success. The use of bactericidal vapors has also been recommended.[16-24] The most recent of these reports described the effects of various glycols on air-borne bacteria. Among the disadvantages of such procedures, one is outstanding, namely, the undesirable contamination of the air with a germicidal agent. Even though the effective concentration of the glycols is relatively low, the continuous breathing of such vapors for long periods may not be entirely harmless.

The chemical solution described here, when used in the special unit, does not escape into the air. Neither does it alter the composition of the air except for reduction in carbon dioxide. It adds no odor to the air. Furthermore, its bactericidal action makes it especially fitted for our experiments on air sterilization.

Preliminary experiments demonstrated that the solution is 12 times as strong as phenol in killing the typhoid and Shiga bacillus. Experiments were also performed to investigate the effect of the solution on other organisms growing on agar plates. The results showed that the growth of many different bacilli was sharply inhibited.

Because of the apparent advantages of this solution, it seemed desirable to study its effect on air-borne infections. Furthermore, since it is already widely used in hospitals and sickrooms as a deodorant, a bactericidal action would be a distinct benefit not only by destroying bacteria responsible for the odor, but especially by helping to eliminate the spread of air-borne infections.

The purpose of this study was confined to a practical evaluation of the efficiency of the machine in removing bacteria from air. The machine and the solution are designed primarily to be used for deodorant purposes. Since they are widely used for this purpose in hospitals and sickrooms, where the spread of air-borne infections is a constant danger, the question arose as to their efficiency in removing bacteria from air.

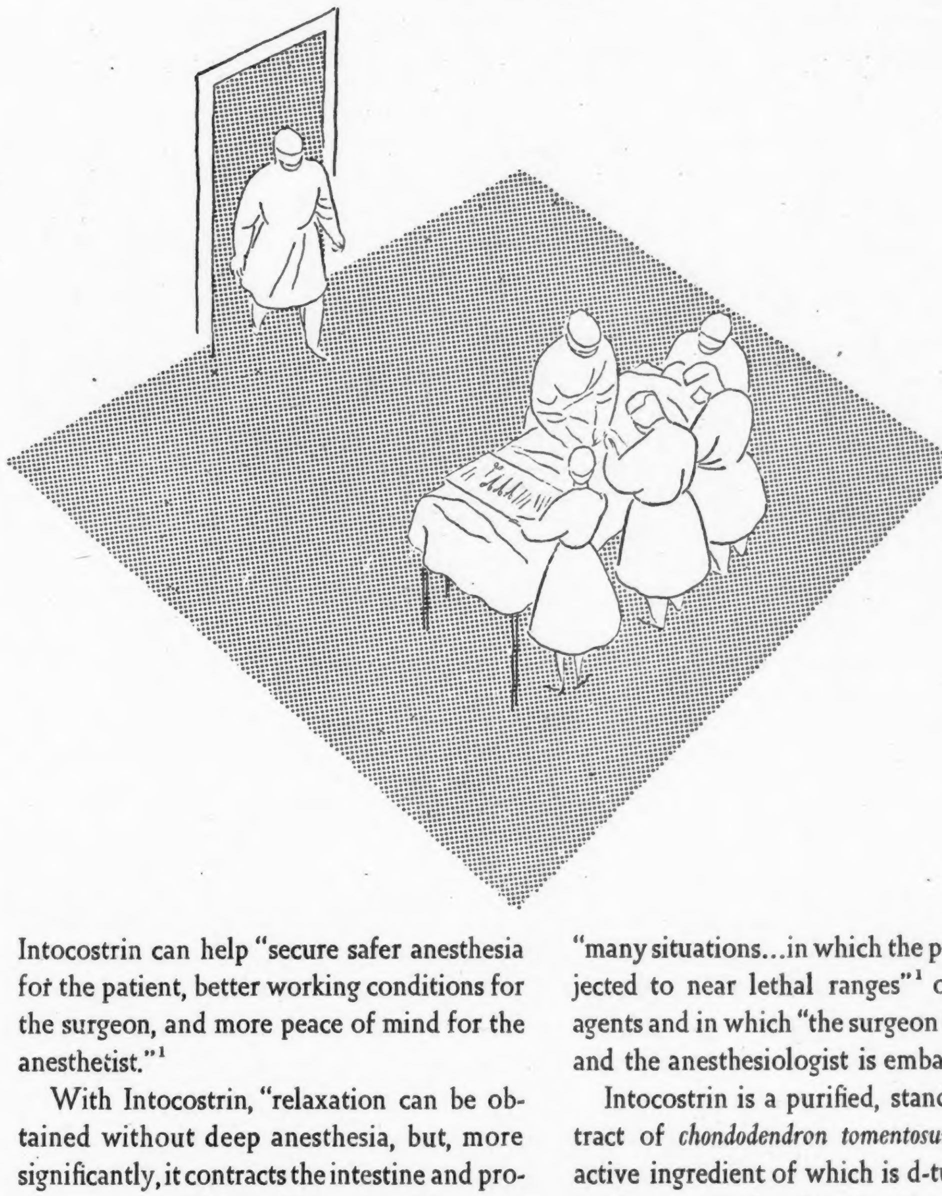
Machine Is Portable

The machine is conveniently small in size (10½ by 12½ by 14 inches), weighs only 23 pounds, is automatic in operation and is portable. The installation is simple. The machine is placed in the room, the solution is added and the unit plugged into an electric outlet. It requires no attention for about twenty-four hours, when more solution is added.

The mechanism consists of a quietly operating squirrel-cage fan which draws the bacteria-laden air through two inlets at opposite ends of the machine and forces the incoming air downward against the surface of the bactericidal solution contained in a porcelain pan locked in the bottom of the unit. After coming in contact with the solution, the air leaves the front of the machine through several rows of vents directed obliquely downward so as not to create a draft near the patient. The rate of air flow through the machine as determined by the manufacturer is about 220 cubic feet per minute. No attempt was made

FROM THE LITERATURE ON A RECENT MAJOR DEVELOPMENT IN SURGERY:

Less frustration for the surgeon—less embarrassment for the anesthesiologist



Intocostrin can help "secure safer anesthesia for the patient, better working conditions for the surgeon, and more peace of mind for the anesthetist."[1]

With Intocostrin, "relaxation can be obtained without deep anesthesia, but, more significantly, it contracts the intestine and produces a quiet abdomen. The quiet abdomen is not obtained at the expense of efficient pulmonary ventilation."[1] No postanesthetic complications have been noted.[2] These valuable effects help eliminate the "many situations...in which the patient is subjected to near lethal ranges"[1] of anesthetic agents and in which "the surgeon is frustrated, and the anesthesiologist is embarrassed."[1]

Intocostrin is a purified, standardized, extract of *chondodendron tomentosum,* the main active ingredient of which is d-tubocurarine, producing muscle relaxation through a readily reversible myoneural block.

1. Cullen, S. C.: Anesthesiology, Vol. 5, No. 2, pp. 166-173 (March) 1944. 2. Griffith, H. R.: Canadian Med. Assn. J. 50:144 1944.

Intocostrin

TRADEMARK

SQUIBB

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Table 1—Organisms Collected in One Hour

Without Machine 6067			With Machine and Solution 14,468	
Exposure Time	*No Machine*		*Machine and Solution*	
Minutes	*Colonies Cu. Ft. Air*	*% Collected*	*Colonies Cu. Ft. Air*	*% Collected*
Control Room	• 59		4	
Spray	43,000		43,000	
0-2	11,562		14,492	
5-7	3,542	30.6	7,026	48.4
10-12	1,524	13.1	5,229	36.8
15-17	492	4.2	1,402	9.6
20-22	295	2.5	521	3.5
25-27	144	1.2	202	1.4
30-32	40	0.34	65	0.44
40-42	15	0.13	18	0.12
50-52	8	0.07	4	0.027
60-62	7	0.065	1	0.006

Room—3,780 cubic feet

by us to confirm the volume of air flow.

The solution is a clear, colorless, odorless, aqueous solution of 2.5 per cent sodium hydroxide and 1.2 per cent potassium mercuric iodide. The loss of solution from the container with the machine operating at full speed was estimated to be nearly 100 cc. per hour.

Under carefully controlled conditions, three separate tests were made: First, the air was heavily contaminated with a diluted culture of the test organisms. Without the machine in the room air samples were collected. Next, the air was heavily contaminated with the diluted culture and air samples were collected with the machine in operation but without any solution. Finally, the air was heavily contaminated with the diluted culture and air samples were collected with the machine in operation, using the solution.

In a later series of experiments this procedure was reversed; air samples were taken first with the machine in operation using the solution, then with the machine running but without the solution, and finally, as a control, samples were obtained from the air in the room when the machine was not running at all.

Repeated careful counts of the number of bacterial colonies in the air samples taken at successive intervals under the various conditions described support the conclusion that the machine and solution are an effective agent for reducing air-borne bacteria. Differences noted in results obtained by operating the machine with and without the solution justify the additional conclusion that the bacteriostatic effect of the solution is effective (see accompanying table).

In a final experiment, bacteria settled on the walls and floor of the room after the original tests were resuspended in the air by means of a blower, then collected on settling plates. Results indicated that the test organism does not survive potently after exposure to the machine-solution treatment.

The experiments described and the results obtained demonstrated the efficiency of a proper chemical solution when used in a satisfactory mechanical device for removing bacteria from the air.

The combination possesses these advantages:

1. It exerts a powerful bactericidal action so that when the test organisms are exposed to the bactericidal solution for even a brief time they do not survive.
2. The unit furnishes a convenient and effective method of removing bacteria from the air.
3. The machine is quiet, portable and virtually automatic. It requires attention only to add solution every twenty-four hours.
4. The solution is not sprayed or

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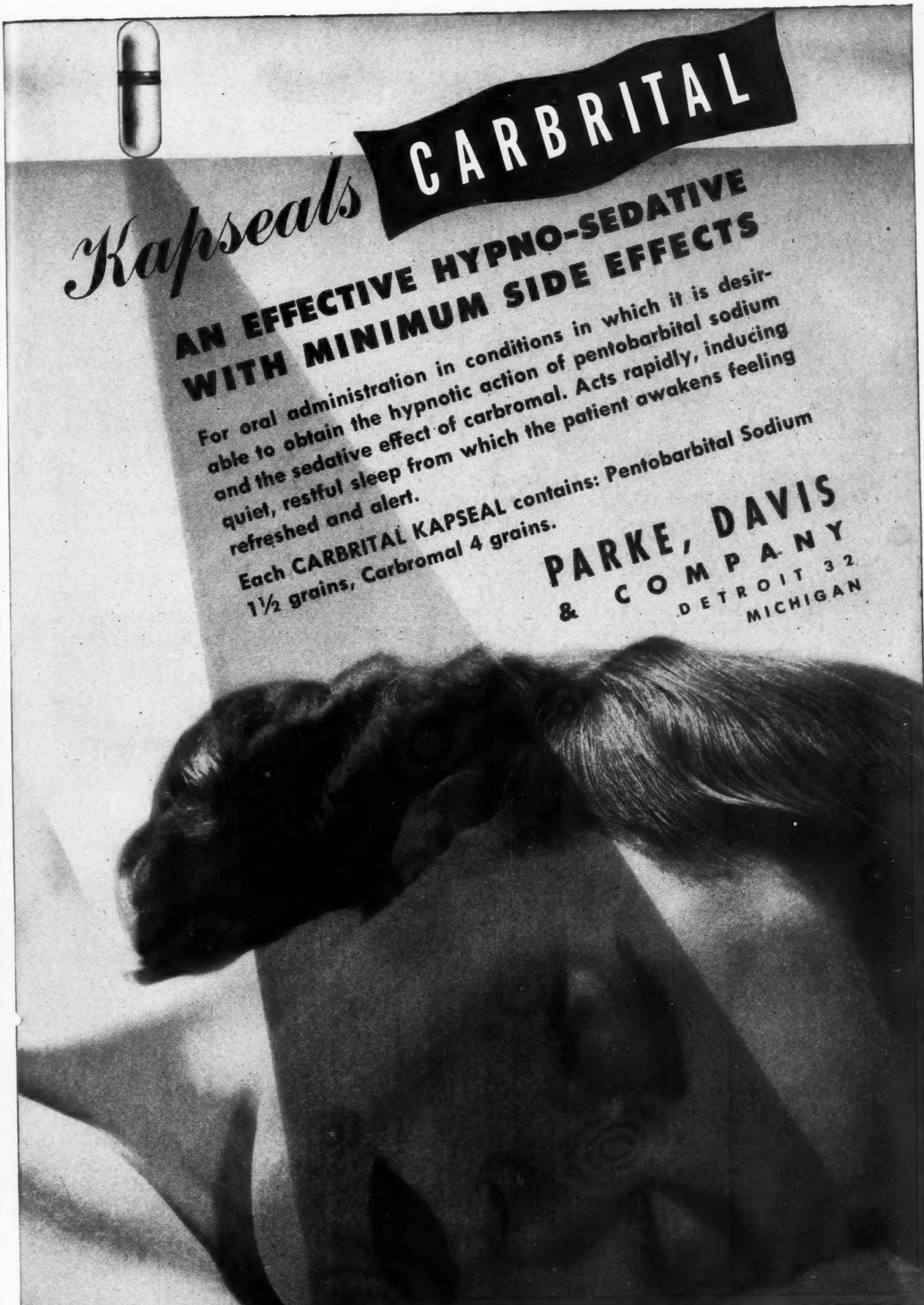
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vaporized into the air and, hence, does not contaminate the air which is being breathed.

5. It does not alter the composition of the air except by reducing the carbon dioxide content.

6. The experiments described in this report suggest that the tested solution, when used in the machine, may be useful in helping to prevent spread of infection caused by airborne bacteria.

Embryonic Induction

C. D. VAN CLEAVE, M.D.

Department of Anatomy
School of Medicine
University of North Carolina

ONE of the major problems in all biology is so fundamental that it is often overlooked or taken for granted. This is the problem of how, out of the originally homogeneous ovum, there arises, in proper order of time and place, the diversity of organs and tissues that comprises the definitive organism.

The problem is not limited to the developing embryo but recurs in the adult in the processes of regeneration, wound-healing, tumor growth and the formation of teratomata.

Fate Not Irrevocably Determined

Modern embryology makes use of the concept of determination, *i.e.* the fixing of the fates of parts of the embryo at a definite time in development. By transplantation experiments it can be shown that in the case of the salamander embryo up to a certain stage of gastrulation, the fates of most of the embryonic regions are not irrevocably determined. A piece of what would have been neural tube, if left alone in the original embryo, will differentiate as external gill if grafted into the gill region of another embryo.

On the other hand, a piece of presumptive skin, if grafted into a suitable neural region of a second embryo, will become brain or spinal cord. At first, therefore, regions of the embryo develop according to their actual environment and without reference to their former surroundings. This plasticity or multipotency includes the germ-layers themselves, for ectoderm and mesoderm, for example, are perfectly interchangeable.

The process of gastrulation, however, is a critical stage in development, for after the three germ-layers come to occupy their normal positions in the embryo, the main fates of the regions are irrevocably determined. The original multipotency of each region becomes severely restricted to a certain special type of development. If grafted into another embryo, the region now differentiates in accordance with its inner determination and not in accordance with the new surroundings in which it has been placed.

One region of the amphibian embryo is an exception to the principle of plasticity that obtains before gastrulation. This region is the dorsal lip of the blastopore, which will become, as a result of infolding during gastrulation, the notochord and somites of the embryo. If a piece of this region is grafted into another embryo which has not completed gastrulation, it will "induce" the neighboring host tissues to form a secondary embryo, usually with completely organized and integrated neural tube, brain, associated sense organs, somites and notochord.

Because this region contains within itself the power to organize competent tissues with which it comes in contact, it was called the organizer by Spemann, who discovered and elucidated its properties. One can define the organizer as a living part of an embryo which exerts a morphogenetic effect upon other part or parts, bringing about their determination as expressed in later histological and morphological differentiation.

The organizer which acts first in development is called the primary organizer and, in the amphibian egg, is the region of the dorsal lip of the blastopore. Corresponding regions in the chick and fish have been identified, and there is no reason to doubt its existence in the mammalian egg. Other organizers acting at successive stages of development are known as secondary and tertiary organizers.

As the potency of parts is successively restricted, they determine the respective fates of smaller regions. The morphogenetic effect brought about by an organizer acting on competent tissue is called induction.

What it is that gives the organizer cells these properties and what the nature of the reaction in the surrounding tissue is have not been ascertained, in spite of much work. Following Spemann's discovery of the living organizer, it was found that dead organizer material or, later, that almost any killed tissue, both embryonic and adult, could effect an induction in competent tissue. Even pure chemical substances held in an agar matrix were effective in inducing neural plate inductions.

Living, Dead Materials Differ

There is one great difference, however, between the response to living normal organizer and that to dead material. The former stimulates the formation of a complete neural plate with normal axial and regional differences, while the latter produces various grades of histotypical neural tissue without regional organization and differences. This fundamental difference between living and dead inductors should have led to restricting the use of the term "organizer" to the living embryonic region so

designated, but in the literature, the terms "organizer" and "inductor" tend to be used interchangeably.

An inductor can be defined as a piece of living tissue, dead tissue, a chemical extract or a chemical substance of known constitution which carries out an induction similar to that performed by an organizer. The word can thus be used indiscriminately for a number of types of inducing agent.

We can now turn to examine the nature of the chemical substance that effects an induction. The assumption that the agent is chemical seemed warranted by the foregoing recital of the types of agent that effect induction. The fact that many tissues, both adult and embryonic, which have no inductive effect when living, acquire this capacity when killed has led to the view that the responsible substance exists in a bound condition in the living cell but is released from this state by the denaturating processes used in killing the tissue.

This view reconciles the similar inductive results obtained when the same tissue has been killed by boiling, drying, immersion in 95 per cent alcohol, xylol and other agents. Needham and his school at Cambridge have isolated sterol derivatives from the organizer and have found that synthetic sterols when applied in a suitable matrix induce the formation of neural tissue. The same inductive effect was obtained by the similar use of a carcinogenic hydrocarbon.

Other different conclusions as to the chemical nature of the inducing substance have been tentatively reached, but it is fair to say that at the present no satisfactory demonstration has been made of the nature of any inductor.

The recent evidence, in fact, exhibits a trend which casts much doubt on the reliability of previous work on the chemical nature of the organizer. It has several times been suggested that dead tissue and the various chemical extracts and substances which were apparently effecting an induction in competent tissue were actually acting only indirectly as inductors.

Their primary effect on the contacting tissue, according to this view, was to cause necrosis of the host tissue. This, in turn, might lead to the release of inducing substances from the dead cells of the host, so that one could derive no reliable information from the nature of the initial substance as to the chemical nature of a living inductor.

The present status of the problem can be summarized as follows: As a result of Spemann's discovery of the primary organizer, it has been experimentally demonstrated that the concept of induction is fundamental to an understanding of tissue differentiation. The increasing heterogeneity of embryonic development has been shown to represent the orderly shunting of cells into pathways of differentiation which are thereafter maintained. These diverse tissues and organs are the morphogenetic effects of a successive series of inductors, each of which has a fairly high degree of specificity.

These inducing substances may become active in adult life in circumstances requiring differentiation or replacement of specific tissues. The nature of these inducing substances is presumably chemical, but, in spite of much work, only the most tentative conclusions have been reached as to their structure.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Victory in Sight

In the November issue of the *Statistical Bulletin* of the Metropolitan Life Insurance Company there appears a good picture of what has happened to tuberculosis mortality in the last thirty-five years. The figures were based on the experience of the many millions of their industrial policyholders. The standardized death rate from the disease among these insured (ages 1 to 74 years) fell from a peak of 223.9 per hundred thousand in 1911-1915 to a low of 34.4 in the first nine months of 1945, a drop of 85 per cent. The largest relative declines occurred in childhood and in early adult life; the smallest improvement took place at the older ages. The mortality rate in the white male age group 5 to 35 years decreased more than 90 per cent; in the 65 to 74 years group the decline was 52 per cent. Females in each race did slightly better than males at the ages beyond 35; before that age, males generally made the better record.

Progress in controlling tuberculosis among the colored, although marked, has not kept pace with the improvement among white persons. Current death rates among colored males is about two and one half times the rate for white males; among females the corresponding ratio is more than four to one. Present day death rates for Negroes are about at the level of those for white policyholders two decades ago.

The fact that the mortality among Negroes is still high and that their improvement in the last thirty-five years has been slower than that for white persons underscores the necessity to intensify efforts to control the disease in this large segment of the population.—John F. Crane.

Neutralizes Effect of Histamine

Of all the ills to which the human being is heir, probably none is more distressing than that which interferes with normal breathing. Burning and itching wheals familiarly known to some as the strawberry rash, hay fever, and certain forms of asthma are all part, some doctors believe, of some disturbance in the metabolic processes in the body that liberate histamine.

To many students of allergic phenonema histamine is responsible for all the symptoms mentioned. The story of the action of histamine is not entirely clear, yet a suggestion that a new chemical has been discovered that neutralizes the effect of histamine should be welcome to the specialist as well as to the general practitioner who is called upon to alleviate the distressing symptoms in bronchial asthma, hay fever and the less disturbing conditions, such as urticaria.

In the current issue of the *Proceedings of the Staff Meetings of the Mayo Clinic* (**20** [23]: 417-445. 1945), a report of a symposium on an antihistamine, benadryl, is presented.

Drs. T. W. McElin and B. T. Horton ("Clinical Observations on the Use of Benadryl: a New Antihistamine Substance," pp. 417-429) describe this new antihistamine as a compound, beta dimethylaminoethyl benzhydryl ether hydrochloride with the simple proprietary name of *benadryl.* This drug appears as a white powder which under ordinary temperature conditions remains stable.

Administered experimentally, benadryl alleviates bronchial constriction

and spasms of smooth muscles induced by histamine. Further, these authors contend, benadryl when compared with other drugs commonly used to counteract the conditions induced by histamine is many times more effective. It is suggested by Doctors McElin and Horton that benadryl's antispasmodic activity has three components. It has antihistamine action, antibarium-chloride effect and anti-acetycholine action.

Clinically, benadryl was administered by the oral, intramuscular and intravenous routes to study its ability to counteract certain well-known clinical effects of histamine. These studies showed that benadryl decreases the cutaneous vasodilating action of histamine, alleviates nasal congestion and depresses the wheal and flare response in cases of hypersensitiveness to cold.

This drug is not free from side effects and the authors list sleepiness, dizziness, dry mouth and nervousness as the usual occurrences; the blood picture remains unaffected.

Drs. P. A. O'Leary and E. M. Farber reported the results of their study on 50 cases of urticaria with this drug ("Benadryl in the Treatment of Urticaria," 429-432). The response of their patients to treatment with benadryl has been dramatic yet only one patient has been observed in whom the cycle of urticaria has been checked after discontinuance of treatment with this drug. Patients who have chronic urticaria often experience spontaneous remissions. Of 50 cases treated, 34 were completely relieved, 12 remained definitely improved and only four experienced no benefit.

Drs. G. A. Koelsche, L. E. Prickman and H. M. Carryer ("The Symptomatic Treatment of Bronchial Asthma and Hay Fever With Benadryl," pp. 432-433) studied the effect of this compound on 83 patients afflicted with hay fever, bronchial asthma or both conditions combined. Fifty-seven patients reported benefit, while those patients affected with hay fever and hay fever associated with asthma showed improvement in 75 per cent. In the bronchial asthma cases of which 12 were treated, four reported improvement while the remainder experienced no beneficial effects.

Dr. H. L. Williams' preliminary report ("Use of Benadryl in the Syndrome of Physical Allergy of the Head," pp. 434-436) concludes that benadryl appears to be useful and deserves more extended clinical trial. Dr. G. B. Logan ("The Use of Benadryl in Treating Some of the Allergic Diseases of Childhood," pp. 436-438) studied the results of benadryl on 18 children suffering from one of the allergic diseases and concludes that the drug is useful if an adequate dose is used.

Dr. C. F. Code in discussing these papers ("A Discussion of Benadryl as an Antihistamine Substance," pp. 439-444) believes that the first of a series of stepping stones to the understanding of histamine metabolism has been established. In this summary he traces the development of the search for antihistamines and the attempts to prove their efficacy. Doctor Code believes that benadryl has established itself as a useful drug in the control of symptoms associated with urticaria and hay fever. In addition, he gives a useful summary, in table form, of the physiological effects of histamine. The author briefly discusses the aftereffects of benadryl.

The public will gladly accept any drug that will relieve the distress of the asthma and hay fever but obviously benadryl is not a "wonder drug" and much more research should be done to determine its beneficial effects and the extent of the possible harm the drug may do. The proportion of the numbers of cases studied to the number of sufferers this drug is to help is still small and the time that the drug has been under experimental consideration has been short.—Michael Levine.

How to Be a GOOD BOSS

WHEN Miss Jones pointed out to Roxie that she was growing careless lately in assembling the salads and that she had been observed to add an extra half plum now and then, Roxie blew up.

Miss Jones had wanted to be tactful and constructive in her criticism. Roxie, she reasoned, had not been long on the job, had caught on more quickly than the average new girl and, heaven knows, girls were still so hard to find and to train that one couldn't take chances on losing help through hasty and ill-considered correctives.

But All to No Avail

But the supervisor's best show of tact elicited from Roxie a flow of tears, an angry retort to the effect that she was tired of being picked on and a hasty exit toward the locker room. When she emerged a few minutes later in her flashy makeup and street clothes, she tossed out with icy dignity the information that she would call for her check tomorrow.

Miss Jones reported this latest kitchen explosion to Mr. Smith, the restaurant manager, who said he would talk to Roxie next day when she came for her check. "Perhaps I can get her to reconsider," the manager said. "Her aunt is a good steady employe and Roxie seems slightly more promising than the usual run. Let me see what I can do."

Before reporting the next day's happenings in this episode from an institutional kitchen we might say that the Roxie Affair here described is an abbreviated review of a dramatic skit given before the recent convention of the National Restaurant Association.

This association has a personnel research program in progress at the University of Chicago and the director of the program, Dr. William Foote Whyte, with a small cast put on the skit while Dr. Burleigh B. Gardner, assistant professor of industrial relations at the same university, commented on the technics employed.

Roxie came back next day with dry eyes and a haughty air and the restaurant manager tried his hand at restoring her to her place at the salad counter.

"We want to be fair to our employes," Mr. Smith, the manager said. "We want them to feel satisfied here, to feel free to come in and talk things over when something bothers them. I have heard Miss Jones' account of what happened yesterday. Now tell me your side of the story and then I'll be able to judge."

"Miss Jones doesn't realize what a nerve-racking job it is," Roxie countered. "She's always looking over your shoulder to catch you on some little thing."

Mr. Smith pointed out the financial import of that extra half plum on every salad plate and of the necessity for each salad's having a trim, crisp and appetizing appearance.

"Maybe I did get a little careless," Roxie admitted, "but Miss Jones doesn't realize what we're up against. If she had ever had to work behind a counter, she'd know how rushed we are."

That in her training period Miss Jones had worked behind the counter, had in fact worked in all the departments, did not impress Roxie when the manager told her of it. If she had done counter work it was at a time when they were not so busy as they are now, Roxie contended.

Mr. Smith explained to Roxie that Miss Jones was responsible to him for the appearance and the content of the salads.

"I just can't take being picked on. Maybe I'm not cut out for this kind of work. Are all jobs like this? Miss Jones has been waiting to call me on something. I'm as neat and careful as anyone. Maybe Miss Jones wanted me to quit. Anyway I can't take it. Give me my pay check."

Pay check in hand, Roxie strode out again. But the two university professors brought Roxie back a second time and had the manager take a tack that came to a successful conclusion. This incident actually took place and the technic employed at the interview that follows worked.

This Time He Listens

Mr. Smith, as the incident is repeated, does not tell Roxie that he wants to be fair, while indicating at the same time that he is still to be the judge; he does not spring to the supervisor's defense. He tries to help the disgruntled employe think clearly. He listens, not half-listens to her story. He accepts the fact that she is irritated, he tries to understand how she feels. He does not talk; he lets her talk. . . .

"I just can't take being picked on. Maybe I'm not cut out for this kind of work. Are all jobs like this?"

"Like what?" Mr. Smith asks.

"Always being caught up on? Miss Jones has been waiting to call me on something. I'm as neat and careful as anyone."

"Do you feel that Miss Jones should not have mentioned the plums?" Roxie was asked.

"I guess that is what she is supposed to do. But I get tired of being corrected—here and at home, too."

"Are you being corrected at home?"

"Yes, I am."

"Did you resent Miss Jones' correcting you?"

"Well, I guess she was supposed to."

"Apparently, then, you don't blame Miss Jones."

"When I took this job I was glad I could be away from home. I thought I could start new. I thought the work would give me freedom. Here I am being bossed again. I guess it must just be me."

Mr. Smith nods his head from time to time, showing interest in Roxie's story, but he makes no comment. With such a sympathetic listener, Roxie continues.

She Was Always Being Bossed

"I left home because I was always in trouble because of their bossing. I went to live with my aunt and pretty soon she began to boss me. I came here and then Miss Jones started bossing me. I feel everyone is superior to me. I'd like to feel as if they weren't running my life for me. There must be something I could do as well as others so no one would correct me all the time. I'd like to do something correct. But in the past I have been corrected so much that pretty soon I did just the opposite."

Mr. Smith listens gravely and attentively.

"I'd like to do the right thing here. Now I resent the way I acted. I'd like another chance.

"You'd like another chance?"

"Yes, I'd like another chance."

"I think that can be arranged."

"Will Miss Jones be resentful?"

"I think Miss Jones will be more interested in the future than in anything else."

And so Roxie is restored to her place at the salad counter.

In commenting on the first and second interviews (unfortunately too much abbreviated for their full and rather subtle effect on the audience of restaurateurs), Doctor Gardner made these suggestions to employers:

1. Try to understand. Listen, don't talk. Don't set yourself up as a judge. Don't be critical. A sympathetic effort on your part can break down more barriers and is worth more than wage increases and clean restrooms.

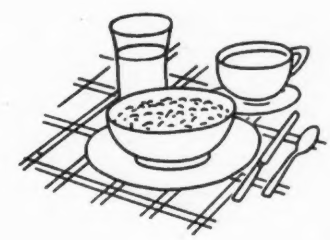
2. Don't try to do it all yourself. Our industrial society is pretty rough on people; executives get ulcers. Just remember that people are not so dumb as they act on any level. The proper skills on the part of those in supervisory and executive positions can make the poorest material into an effective work team.

Change the lenses on your glasses. Your employes may be real people with lots on the ball. You may be making no effort to let them decide anything. Find out what satisfactions that troublesome guy is seeking. It may take very little to make him a part of the team. In some cases the "troublemaker" is just stronger than you are. Why stick that label on him! If given a chance, he would probably prefer to proceed peacefully.

And those colored girls you hired when you could not get whites. They are probably better educated than the white girls. Don't generalize.

3. Praise; don't criticize. You can find something to praise in everyone. Ask employes' advice about things. By such simple devices as honest praise and interest in their opinions you can change the whole attitude of a place within a month.

4. If you can't control the outer world, learn to adapt to it. Change your behavior systematically. Don't decide you are right and your subordinates are wrong. Get people to work with you in a supervisory capacity who have the courage to say "Well, maybe I do that wrong; I'm going to change."



FOOD FOR THOUGHT

Good Book on Nutrition

Dietitians are occasionally asked by patients, young mothers and friends to recommend a good book on nutrition.

Edna P. Amidon, chief of home economics, U. S. Office of Education; Dorothy Bradbury, Children's Bureau, and Vivian Drenckhahn, W.F.A., have written "Good Food and Nutrition" (John Wiley & Sons, Inc., $1.96) which covers marketing, cooking, meal planning and preserving, in addition to the feeding of small children.

Taste Before Serving

Most of the compaints about the food can be avoided if the dietitian and her staff will inaugurate a tasting service.

This is the opinion of one of the leading Canadian restaurant supervisors, Violet M. Ryley, who is head of all the tea rooms and cafeterias for T. Eaton Co., Ltd.

Fifteen minutes before serving time, Miss Ryley and her staff start on their rounds. They test each dish for (1) flavor, (2) texture, (3) color, (4) temperature, (5) size, (6) shape and (7) arrangement. They view salads from the standpoint of freshness, crispness, rightness, beauty of color and contrasts.

"Add salt." "Add sugar." "Add lemon juice." In practically every case some such admonition must be given. To Miss Ryley tasting takes precedence over everything else in food service.

The staff tastes the meats, the first cooking of vegetables, soups, gravies, salads, dressings, desserts, coffee, fruit juice cocktails. Almost every item seems to need a dash of something to bring it up to prime flavor.

"Recipes are not enough," Miss Ryley declares. "The soil, the amount of sunshine and the variety of the food contribute to the end result and recipes don't take care of all of these."

Dishwashing Technics

for Cleanliness and Safety

"REQUIRE your dishwashing crew to rinse all dishes and silverware for ten seconds at a temperature of 170° F. if you expect to reduce the bacteria to a safe level."

This conclusion has been arrived at in the first project undertaken by the National Sanitation Foundation at Michigan State College. The foundation is sponsored by the National Restaurant Association.

The foundation's bacteriologists working on this project found that in a five second interval at 165° the bacterial population was reduced 78 per cent; in a five second exposure at 170° the reduction was 88 per cent. In a ten second exposure at 165° the reduction was 90 per cent and in a ten second exposure at 170° the reduction was 97 per cent.

The second project being undertaken at this college concerns the dishwashing procedure itself. This research is not yet complete. Machines from five manufacturers are being used in the experiments.

Three other institutions of higher learning are carrying on research on dishwashing compounds and detergents under National Restaurant Association sponsorship.

"No matter how much dishwashing machines are improved, unless the institution has properly trained personnel to operate the machines at the standards recommended the value is lost," warns Dr. W. L. Mallmann, director of bacteriology at Michigan State College.

Six manufacturers of dishwashing equipment who are sponsor members of the National Sanitation Foundation have prepared the following check list for use in checking dishwashing operations.

CHECK LIST of DISHWASHING OPERATIONS

DISHWASHING MACHINE

- ☐ Cleanliness inside and outside
- ☐ Spray openings washed and pipes cleared
- ☐ Openings rinsed clean
- ☐ Hose provided for daily cleaning of tables and machine
- ☐ Machine in good working order

SOILED DISH TABLE

- ☐ Drain to prevent liquids and food from getting into machine
- ☐ Scrapping arrangements provided (see report No. 1 on study sponsored by National Restaurant Association)
- ☐ No soil that will mark dishes

UNLOADING FACILITIES

- ☐ Container for depositing silverware
- ☐ Spot for placing and draining soiled cups
- ☐ Place for piling trays
- ☐ Convenient arrangements for racking or stacking plates

CLEAN DISH TABLE

- ☐ Table large enough to allow one minute for dishes to drain and air-dry
- ☐ Shelves on which to place containers for clean cups
- ☐ Shelves for convenient stacking of plates and other tableware, saving floor space
- ☐ Sink for soaking dishes with "baked-on" food
- ☐ Arrangements for eliminating need for lifting of heavy loads
- ☐ Slide for returning empty racks to loading zone
- ☐ Rack storage: ample supply of racks in good condition

CLEAN DISH STORAGE

- ☐ Storage space enclosed to prevent contamination by air-borne bacteria
- ☐ Plate warmer shelves of wood or stainless metal to eliminate possibility of marking dishes

DISH PANTRY

- ☐ Good lighting for good inspection
- ☐ Acoustic treatment of room and tables
- ☐ Good ventilation for quick air-drying of dishes and pleasant working conditions that contribute to efficient work by workers
- ☐ Ample hot water supply delivered to machine at temperature of 170° or above for required bacteria reduction and quick air-drying of dishes
- ☐ Booster heater for raising temperature of hot water taken from building supply to 170° or above for good rinsing of dishes in the machine

ORGANIZING THE HELP

- ☐ Recognition of foreman of dishwashing department as man in charge by other department heads and kitchen personnel
- ☐ Appreciation by foreman of fact that he is responsible for:
  - a. Production of clean dishes, including regular inspection and periodic removal of stains
  - b. Control of breakage, including regular reports

(*Continued on Page 116*)

NOW AN ALUMINUM ALLOY

with elephant-hide toughness for your kitchen equipment

As fast as we can convert, new Wear-Ever equipment is being made of a tougher, harder aluminum alloy than ever before practical. Think what this means in even longer wear—in lasting economy that cuts maintenance costs.

Because it is so hard, this new aluminum alloy, with its famous Smoothard finish, offers unparalleled resistance to denting and scratching. Equipment made from it retains its shape—stays smooth, new-looking and easy-to-clean.

That's not all. You'll like the way Wear-Ever aluminum cooking equipment spreads heat quickly and evenly. Aluminum is friendly to foods, too, protects their flavor, taste and purity. And it's light to handle.

Wear-Ever equipment in the extra-hard alloy is on its way. Tell us your needs. The Aluminum Cooking Utensil Company, 705 Wear-Ever Building, New Kensington, Pa.

Wear-Ever Aluminum Steam Jacketed Kettles

Records attest to the fact that prewar Wear-Ever kettles often lasted for 20 or more years. Think how much longer the new kettles, made from this even tougher alloy, will last.

WEAR•EVER ALUMINUM

WEAR-EVER ALUMINUM TRADE MARK REG. U. S. PAT. OFF.

c. Maintenance of high standards of cleanliness by daily cleaning of the dishwasher, dish tables and floor

d. Training of personnel for this department

- ☐ Regular inspection of all tableware, including checking and rejection of any that is not fit for further use and dipping or scrubbing those pieces that show accumulation of stains
- ☐ Employment of good help; personnel measuring up to standards required for other departments
- ☐ Recognition of importance of clean dishes and the fact that dishwashing can be pleasant work

OPERATION OF DISHWASHING EQUIPMENT

- ☐ Operating instruction supplied by manufacturer mounted on wall or available for reference
- ☐ Daily cleaning of machine, including cleaning of wash pipes and rinse sprayers
- ☐ Scrapping of dishes so that left-over food and liquids are kept out of machine
- ☐ Racking dishes for good washing: plates on end; cups and bowls upside down in open racks; light loading of silverware
- ☐ Strainer pans (and pump intake strainers if used) kept in place
- ☐ Good detergent with dispenser properly used or other provision for maintaining strength of washing solution without wasting compound as recommended by supplier
- ☐ Washing and rinsing as specified in manufacturer's instructions
- ☐ Rinse system: daily inspection and removal of pipe scale as required; use of line strainer.
- ☐ Dishes washed while fresh or soaked if they have been allowed to stand for some time
- ☐ Chinaware allowed to drain and air-dry; silverware and glassware toweled while piping hot
- ☐ Rigid inspection; rewashing of any pieces that are not prefectly clean
- ☐ Dishes handled to preserve cleanliness: clean hands touching only handles of cups and silverware, rims of plates and bottoms of glasses
- ☐ Careful handling, transporting and storage of clean tableware
- ☐ Time and motion study: operators working on basis resulting in high production with minimum effort; opportunities for reducing waste effort

MAINTENANCE OF EQUIPMENT

- ☐ Responsibility delegated to a competent mechanic; either an employe or an outside service
- ☐ Regular lubrication of motor and all parts as specified in manufacturer's instructions
- ☐ Operation of parts checked as suggested by manufacturer
- ☐ Periodic cleaning and removal of alkali deposits
- ☐ Adjustment of gas burners for good combustion; checking of pilot light and thermostats
- ☐ Pump packing: tight enough to stop excessive leaking but not tight enough to overload motor
- ☐ Valves: tightening packing around valve stems; replacing disks and/or reseating where valves leak and waste water; tightening valve handles
- ☐ Electric parts: protected against damage by water; motor commutator cleaned; switch in good working order

Around The Wards With Kellogg's

PATIENT GUS: The Doc says me rugged constitution pulled me through. *I* says thinkin' about eatin' Kellogg's Cereals for the rest of me life kep' up me will to live. (Most people like Kellogg's *most.*)

NURSE DEERING: Do I like Kellogg's Individuals? If *you* handled 40 breakfast trays you'd appreciate the labor-saving convenience of these packages. Like 'em? They're the nurse's best friend!

DIETITIAN DAVIS: The 9 Kellogg's Cereals are morale builders. They look appetizing on hospital trays. Impressive food values, and patients are highly amenable...Oh, dear! Now *I'm* getting hungry!

GREAT NUTRITION: Kellogg's Cereals are made from whole grain or are restored with important whole-grain food elements essential to human nutrition, in accordance with the U.S. nutrition program.

Here's Another Great Time and Dish Saver

THE EXCLUSIVE KELLOGG KEL-BOWL-PAC

1. Open the package ....

2. Add cream and fruit.......................

3. Eat right out of the leak-proof package ....

Be sure your wholesaler salesman keeps your assortment of Kellogg's complete at all times.

Made by Kellogg's —THE GREATEST NAME IN CEREALS
of Battle Creek and Omaha

Menus for June 1946

Grace Dougan
Brewster Hospital
Jacksonville, Fla.

1
Stewed Prunes
Bacon, Toast
•
Roast Beef, Brown Gravy
Parsley Potatoes
Peas
Apricot Whip
•
Plain Broth
Sliced Ham
Potato Salad
Buttered Asparagus
Egg Custard

2
Grapefruit Halves
Soft Cooked Eggs
Toast
•
Chicken Fricassee
Cranberry Sauce
Mashed Potatoes
Creamed Cauliflower
Peach Ice Cream
•
Vegetable Soup
Cod Fish Balls With Tomato Sauce
Curled Celery
Fruit Gelatin

3
Stewed Apricots
Ham Omelet
Toast
•
Clear Beef Broth
Meat Pie With Potatoes and Carrots
Strawberry Shortcake
•
Cream of Potato Soup
Toasted Cheese Sandwiches
Apple Salad
Gingerbread With Lemon Sauce

4
Sliced Peaches With Cream
Poached Egg on Toast
•
Roast Pork, Brown Gravy
Glazed Sweet Potatoes
Turnip Greens
Fried Apples
Bread Pudding With Fruit Sauce
•
Chicken Soup
Lettuce and Peanut Butter Sandwiches
Banana Salad
Oatmeal Cookies

5
Stewed Apples
Link Sausages
Raisin Toast
•
Roast Veal, Gravy
Creamed Potatoes
Green Black-Eyed Peas
Diced Beets
Ice Cream
•
Mushroom Soup
Broccoli With Hollandaise Sauce, Bacon Strips
Lemon Pie

6
Fruit Juice
Soft Cooked Eggs
Toast
•
Spiced Baked Ham
Candied Yams
Buttered Spinach
Bread and Butter Pickles
Devil's Food Cake
•
Split Pea Soup
Spaghetti With Meat Balls
Head Lettuce Salad
Ice Cream

7
Pineapple Juice
Sausage Patties
Toast
•
Salmon Loaf With Chili Sauce
Mashed Potatoes
Green Peas
Blackberry Pie
•
Cream of Potato Soup
Cold Roast Beef
Carrot and Raisin Salad
Baked Chocolate Pudding

8
Apple Juice
Ham Omelet
Toast
•
Smothered Round Steak
Mashed Potatoes, Brown Gravy
Brussels Sprouts
Pound Cake
•
Potatoes Au Gratin
Lettuce and Tomato Salad
Hot Rolls
Peach Ice Cream

9
Kadota Figs
Soft Cooked Eggs
Hot Biscuits
•
Stewed Chicken
Steamed Rice
Buttered Spinach With Sliced Boiled Eggs
Sliced Tomatoes
Ice Cream
•
Cream of Tomato Soup
Tuna Salad
Curled Celery and Carrot Strips
Apple Brown Betty

10
Bananas
Eggs in Shell (hard or soft)
Bran Muffins
•
Broth With Rice
Veal Chops
Mashed Potatoes
String Beans
Peach Cobbler
•
French Onion Soup
Soy Bean Salad
Hot Rolls and Jelly
Ice Cream

11
Cheese Omelet
Toast and Jelly
•
Lamb Stew
Oven-Browned Potatoes
Buttered Lima Beans
Prune Whip
•
Split Pea Soup
Cold Sliced Ham
Fruit Salad
Fresh Coconut Cake

12
Sliced Peaches
Bacon Strips
French Toast, Sirup
•
Pork Roast With Dressing, Gravy and Applesauce
Candied Sweet Potatoes
Steamed Cauliflower
Corn Bread
Ice Cream
•
Clam Stew
Baked White Potatoes
Tomato Salad
Rolls
Pound Cake

13
Fruit Juice
Sausage Patties
Biscuits
•
Veal Chops, Gravy
Creamed Potatoes
Buttered Peas and Carrots
Apple Pie
•
Cream of Mushroom Soup
Potato Salad
Cold Sliced Tongue
Pears

14
Mixed Fruit
Soft Cooked Eggs
Toast
•
Fried Fish
Mashed Potatoes
Tomatoes With Okra
Lemon Gelatin
•
Navy Bean Soup
Veal Cutlets
Asparagus Salad
Apricot Whip

15
Bananas With Cream
Ham Omelet
Toast
•
Lamb Pie
Mashed Rutabagas
Mixed Vegetable Salad
Plain Cake With Chocolate Sauce
•
Clear Soup
Macaroni With Cheese
Cabbage Salad
Watermelon

16
Kadota Figs
Soft Cooked Eggs
Hot Muffins
•
Baked Chicken and Dressing, Gravy
Mashed Potatoes
Peas
Hot Rolls
Ice Cream
•
Creamed Oyster Soup
Cold Lunch Meat
Fruit and Nut Salad
Sweet Potato Pie

17
Applesauce
Griddle Cakes, Sirup
Bacon
•
Veal Chops
Candied Yams
Buttered Kale
Sliced Tomatoes
Corn Muffins
Chocolate Cookies
•
Vegetable Soup
Frankfurters
Coleslaw
Fudge Brownies

18
Grapefruit Halves
Bacon
Bran Muffins
•
Roast Lamb With Mint Sauce
Baked Potatoes
Turnip Greens
Ice Cream
•
Cream of Celery Soup
Deviled Eggs
Buttered Asparagus
Lemon Cheese Cake

19
Apple Juice
Bacon Strips
Hot Biscuits
•
Beef Pot Roast With Peas, Onions and Carrots
Mashed Potatoes
Blackberries and Cream
•
Cream of Pea Soup
Tomato Rings With Shrimp
Cucumber and Pea Salad
Watermelon

20
Pineapple Juice
Omelet
Toast
•
Stewed Kidneys
Hashed Brown Potatoes
Summer Squash
Cantaloupe
•
Lima Bean Soup
Crisp Bacon
Asparagus Salad
Cookies

21
Stewed Peaches
Scrambled Eggs
Hot Muffins
•
Baked Stuffed Fish
Baked White Potatoes
Cauliflower With Thin White Sauce
Cabbage Salad
Raspberry Chiffon Pie
•
Cream of Spinach Soup
Cheese Puffs
Pineapple and Banana Salad
Angel's Food Cake

22
Mixed Fruit Juice
Sausage Patties
Toast
•
Broth With Vegetables
Cheese Fondue
Buttered Whole Kernel Corn
Tomato Salad
Pecan Pie
•
Mutton Broth
Eggs in Casserole
Pickle, Celery and Lettuce Salad
Plain Cake

23
Sliced Bananas With Top Milk
Scrambled Eggs
Toast
•
Roast Chicken With Dressing, Giblet Gravy
Steamed Rice
Buttered Spinach
Ice Cream
•
Oxtail Soup
Sliced Cold Beef
Apple and Pear Salad
Cookies

24
Tomato Juice
Soft Cooked Eggs
Hot Biscuits
•
Escalloped Potatoes With Ham
Buttered Wax Beans
Beet Salad
Pineapple Upside-Down Cake
•
Split Pea Soup
Sliced Bacon
Tomato Salad
Watermellon

25
Mixed Fruit Juice
Griddle Cakes, Sirup
Smoked Sausage
•
Broiled Veal Chops
Mashed Potatoes
Buttered Peas
Gingerbread With Lemon Sauce
•
Turkey Soup
Shrimp Salad
Stuffed Squash
Prune Plums

26
Sliced Peaches
Cheese Omelet
Hot Muffins
•
Stewed Chicken, Yellow Gravy
Cranberry Sauce
Mashed Potatoes
Fresh Butter Beans
Coffee Layer Cake
•
Clam Chowder
Boiled Ham
Sliced Tomatoes
Watermelon

27
Apricot Nectar
Fried Eggs and Bacon
Toast
•
Beef Stew With Peas, Onions, Potatoes and Carrots
Cabbage and Raisin Salad
Lemon Chiffon Pie
•
Vegetable Soup
Cold Sliced Tongue
Soy Bean Salad
Oatmeal Cookies

28
Stewed Prunes
Plain Omelet
Toast
•
Baked Fish With Dressing
Parsley Boiled Potatoes
Stewed Tomatoes
Coleslaw
White Layer Cake
•
Chicken Bouillon Soup
Potato and Egg Salad
Stuffed Eggplant
Cantaloupe

29
Tomato Juice
Bacon
Bran Muffins
•
Escalloped Potatoes With Ham
Buttered String Beans
Beet Salad
Jelly Roll
•
Split Pea Soup
Stuffed Pepper With Meat
Macaroni Salad
Apple Brown Betty

30
Vegetable Juice
Ham and Eggs
Hot Biscuits
•
Stuffed Lamb Roll
Potato Soufflé
Baked Corn
Molded Cucumber Salad
Hot Rolls
Pineapple-Cherry Chiffon Pie
•
Fresh Vegetable Soup
Flaked Fish Salad
Stuffed Celery
Watermelon

These menus feature food preferences and habits that are characteristic of the South.—ED.
Ready-to-eat or cooked cereals are offered on all breakfast menus.

Sunway BEVERAGE BASE

fortified with Vitamin B_1 and C
available in Orange, Lemon and Lime Flavors

12-Oz. Can Makes 4 Gallons of Beverage

This can when packed contained 7.69 GMS. of VITAMIN C (Ascorbic Acid) and .0649 GMS. VITAMIN B_1 (Thiamine Hydrochloride).

The FINISHED BEVERAGE, made according to directions on label, will contain 120 MGS. VITAMIN C, 1.0 MG. of VITAMIN B_1 and 116.3 CALORIES, TO EACH 8-OZ. GLASS.

This provides 100 and 400 per cent respectively of the adult minimum daily requirements for VITAMINS B_1 and C.

19 OUNCES of FRESH NATURAL, tree-ripened FRUIT JUICE was used in the making of this 12-ounce can of DEHYDRATED SUNWAY BEVERAGE BASE.

Sunway Beverage Base makes it possible to supply nutritious beverage juices at a moment's notice in hospitals, institutions, etc. A beverage base that furnishes high nutritional values of citrus juices and of ascorbic acid and thiamine hydrochloride . . . at a minimum of expense.

These delicious new dehydrated fruit juice flavors are developed by a new and exclusive process and are ***Easy to Prepare*** — just add water and sweeten.

So Economical to Use—One 12-ounce can of SUNWAY BEVERAGE BASE makes 4-gallons of true fruit beverage, and costs only $1.50. Cost of 8-oz. glass of "Sunway", including sugar is approximately 2½ cents.

★

If you have not tried SUNWAY BEVERAGE BASE, send for details today.

Sunway Beverage Base has been accepted by the Council on Foods and Nutrition of the American Medical Association.

SUNWAY Fruit Products
CHICAGO 11, ILLINOIS

Let's Get Rid of the Ice Nuisance

LOUIS AXELBANK

Mechanical Engineer
Bureau of Architecture
Department of Public Works
New York City

THE manufacture and distribution of ice in hospitals constitute a serious problem from the point of view of sanitation as well as of convenience.

Hospital administrators have been aware of the danger of contamination and the possible spread of an epidemic inherent in the present method of supplying ice for cooling drinks. They have been equally aware of the nuisance involved in the transportation of the ice through the wards, its temporary storage in serving pantries and utility rooms, the messy way of breaking it down to fit ice caps and collars and the need for frequent removal of the water from melting ice used for cooling oxygen tents. They also could not help observing the wastefulness involved in the process of making, crushing, storing and transporting the ice.

Little Has Been Done

It is, therefore, surprising that so little has been done to improve the methods of supplying this necessary utility in hospitals. In this respect, even our most modern hospitals are still in the age when ice was harvested from lake and stream in winter and stored in sawdust for the summer. Substituting artificial means for nature's way of freezing has not eliminated the handling which constitutes the major cause of contamination. Similarly, the use of a mechanical ice crusher in place of the pick and axe has not helped to make the ice more sanitary. In addition, the ice pick and wooden mallet are still needed in most hospital utility rooms.

This lack of progress in providing sanitary means of supplying ice, or its equivalent cooling effect, can be traced to the lack of knowledge on the part of hospital administrators and their plant engineers as to improved methods developed for the purpose. They have not the time or resources to investigate for themselves. The manufacturers apparently have not found the demand from hospitals sufficient to warrant much advertising of this type of equipment. The war has been a contributing factor during the past few years in preventing the developing and marketing of new equipment. The few hospitals that have pioneered in trying out new methods have not spread the knowledge and experience gained about the performance of the new machines and tools.

It is my belief that the use of ice in hospitals could be almost entirely eliminated. Electrically operated cooling equipment could be substituted for all major ice needs and for most of the minor ones. The remaining few minor ice needs, representing probably not more than 5 per cent of the total, would be supplied by a small electrically operated automatic ice maker.

The following account of the investigation and study upon which these conclusions are based is contributed in the spirit of sharing all the information that would help others to arrive at the same conclusions. It is hoped that sufficient interest in the subject may be aroused to stimulate a concerted effort to rid our hospitals of the ice nuisance and thus take another step toward making them really modern.

In Search of Improved Methods. In developing its postwar building program, New York City, through the bureau of architecture of the department of public works, instituted various research projects, including one intended to improve the methods of making and distributing ice in its hospitals. The general objectives of this project were: (1) to determine the actual needs for ice in the various departments of different types and sizes of hospitals; (2) to analyze these needs with the aim of substituting electrical means for producing the same cooling effect, wherever possible and (3) to replace the present central ice making system by a modern decentralized system for the remaining needs that only ice could satisfy.

Three Months' Study Made

The first phase of the project covered a period of about three months of intensive study and investigation. Visits were made to a number of city-owned, as well as voluntary hospitals, large and small, general and chronic, mostly in and around New York City, and the ice problem in each was studied at first hand. Superintendents, nurses, dietitians, chefs, oxygen therapists, engineers, ice plant attendants and porters were interviewed and their experiences and suggestions on the subject were noted and coordinated.

Several hospitals that could not be visited were reached by telephone or correspondence. Hospital magazines covering a period of several years were scanned for new ideas and suggested leads were followed up. Manufacturers of hospital and refrigerating equipment were consulted, the problem was discussed with them from all angles and their latest products were inspected.

The second phase of the project consisted of about a year of periodic follow-up, check-up and watchful waiting. Because of their preoccupation with war production, the manufacturers of the equipment were not willing to make any prediction as to their plans for improving and marketing their products. In the meantime, the city's future hospital buildings were in the process of being designed and certain decisions had to be made in regard to ice making. Some of these decisions were

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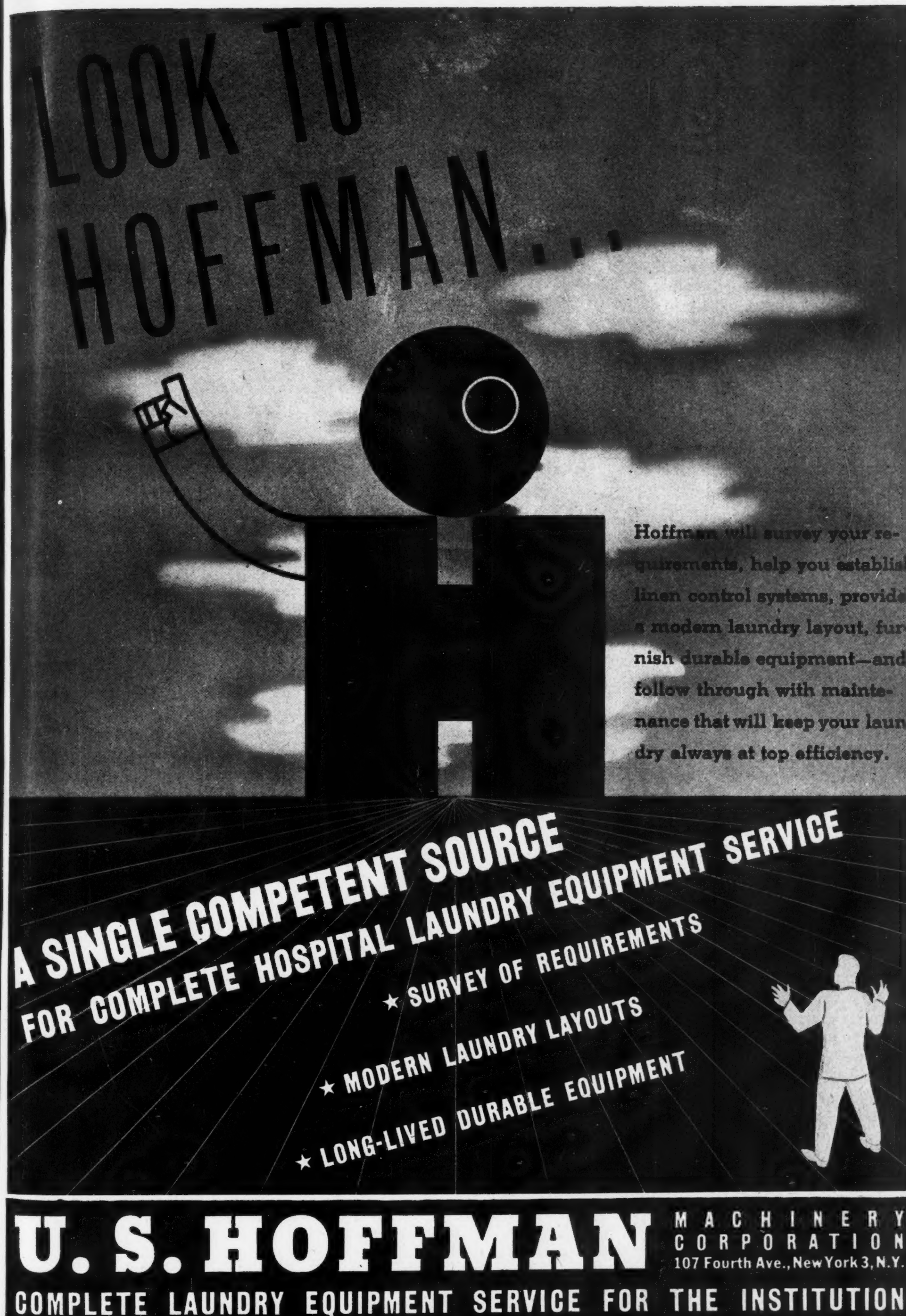
This is the first article of a series by Mr. Axelbank. The second and third sections of his discussion will appear in the June and July issues.


LOOK TO HOFFMAN...
Hoffman will survey your requirements, help you establish linen control systems, provide a modern laundry layout, furnish durable equipment—and follow through with maintenance that will keep your laundry always at top efficiency.
A SINGLE COMPETENT SOURCE
FOR COMPLETE HOSPITAL LAUNDRY EQUIPMENT SERVICE
★ SURVEY OF REQUIREMENTS
★ MODERN LAUNDRY LAYOUTS
★ LONG-LIVED DURABLE EQUIPMENT
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MACHINERY CORPORATION
107 Fourth Ave., New York 3, N.Y.
COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

final, others were tentative and they were reached after a careful weighing of all the findings to date, with the understanding that changes would have to be made before the buildings were constructed.

Findings Grouped. The results of the investigation and study have been grouped under a large number of headings. The headings were intended as an aid to those who are not interested in all phases of the problem so that they could concentrate on the parts which seemed to them essential and skim or skip over the remainder. It is to be expected that what may appear to some as self-evident and dated may be new and of benefit to others.

Ice Needs in Hospital. All hospitals use ice; some more, some less. Some use it for many purposes, others for only a few, depending on the type of hospital and the preferences of the administrator and the medical staff. In order to make the findings applicable to all hospitals it was necessary to investigate all possible uses.

The list that follows is believed to be all-inclusive. The items are given in the order of their importance judged by the universality of their use or the relative quantities consumed.

The major uses, which account for perhaps 90 per cent of the total, are: (1) in drinking water, (2) for cooling oxygen tents and (3) for ice caps and collars.

Minor uses in the dietary group include: (1) temporary cooling before serving of salads, fruit juices, desserts, cream, milk and butter patties; (2) cooling beverages, such as coffee and tea, in summer time; (3) icing fish; (4) cooling water in which peeled potatoes are kept temporarily, and (5) making ice cream.

In the therapeutic group the uses are: (1) for surgical anesthesia; (2) in water for compress and pack applications; (3) in cooling tubes for stomach lavages and gastric analyses, and (4) for swallowing prescribed for some postoperative cases and hemorrhages.

Quantities of Ice Used. A serious attempt was made to determine the amount of ice needed for the enumerated uses, individually or in groups, based on the bed capacity of the hospitals investigated. However, the paucity of reliable information and the excessiveness of the variations in the data obtained made it impossible to arrive at average figures that would be of any real value. Still it may not be amiss to give some figures which, while they may be considered as mere guesswork, may be found useful if applied with discrimination.

Rough estimates were made from all sorts of data obtained in a number of general hospitals of from 250 to 600 bed capacity. The results given as average amounts of ice used in a summer day were: 7 pounds per bed for all needs (except cooling of oxygen tents) for patients in wards and 3 pounds per bed for dietary needs in the main kitchens and all dining rooms. Of the former amount, drinking water cooling accounted for from 50 to 75 per cent; of the latter amount, the bulk was used for drinking water and beverage cooling.

Amounts used for oxygen tent cooling were particularly difficult to estimate on a per bed basis because the number of tents used seems to bear no relation to the number of beds in the various hospitals visited. The range is from a high of one tent to 30 beds, down to a low of one to 300, while in one very large general hospital no oxygen tents were used except when occasionally requested by a private patient. In an article published in the April 1945 issue of The Modern Hospital, one to 50 beds is the figure given for one hospital. An average of one tent to 75 beds and an average of 450 pounds of ice per tent for a summer day would result in a figure of 6 pounds per bed.

Methods of Making and Distributing Ice. With few exceptions, all the hospitals investigated manufacture ice in 50 or 100 pound cakes or blocks in a central plant in the basement. Only one of these hospitals buys ice in crushed form from an ice manufacturing concern which makes deliveries twice a day. A brief description of the ice making and distributing process in these central plants will give an idea of the insanitary and wasteful conditions inherent in this system of supplying ice for hospital needs.

The ice cakes are made in a checkerboard series of rectangular cans, immersed in a tank containing brine at a temperature sufficiently low to freeze the water. The top of the tank, which serves as a floor for the men to work on in filling and emptying the cans, consists of a wooden framework with removable wooden covers over the cans.

The process starts with filling the cans with water and lowering them into the tank. A period of twenty-four hours is usually allowed for full freezing and then the ice is "harvested." That means lifting the cans with the ice out of the brine with a mechanically or electrically operated hoist, transporting them to the dumping machine, where hot water is sprayed to thaw out the ice cakes, and "dumping" the cakes into an insulated and refrigerated storage room, where they are maneuvered into position by hand and tongs and stacked along the walls.

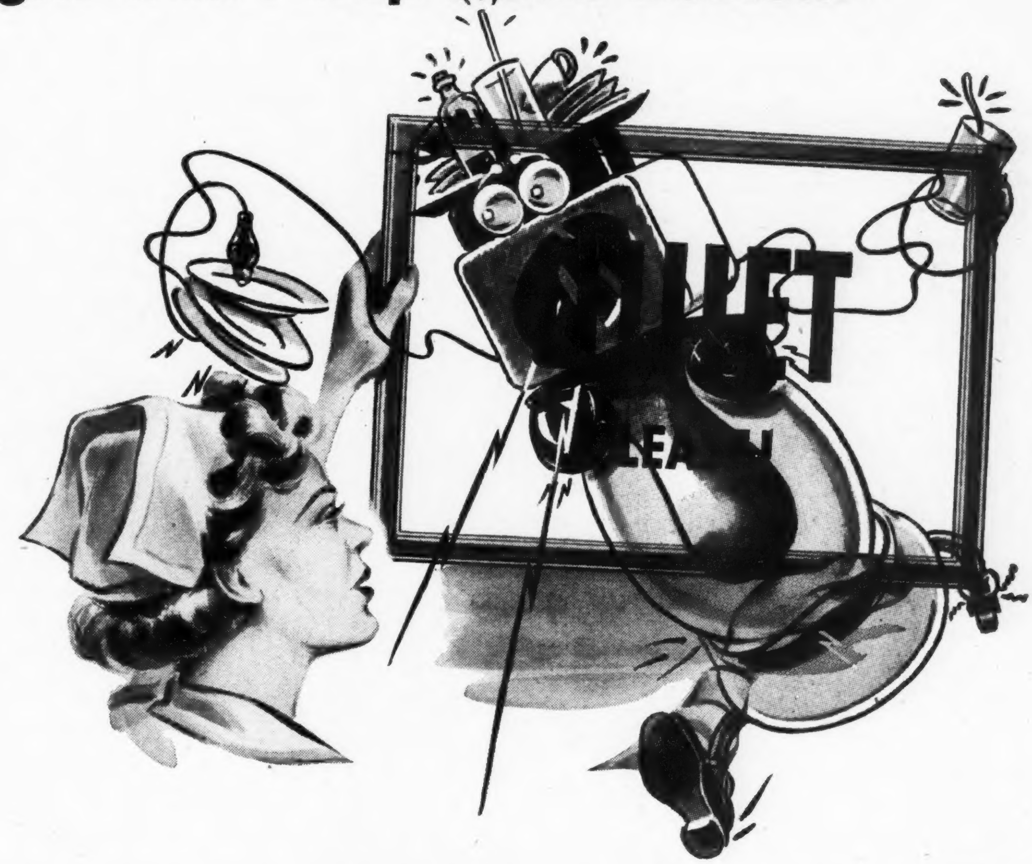
Two or three times a day some of the ice cakes are removed from the storage room; broken by a mechanical crusher (in some cases by hand with a pick and axe); transported in a variety of containers, including garbage cans and butter tubs, on hand trucks, and delivered to main kitchens, ward serving pantries and utility rooms for immediate use or temporary storage in refrigerators or special cabinets.

In some of the larger hospitals comprising a number of buildings, the ice is delivered to two or more buildings in cake form to be stored, crushed and delivered from there to the points of ultimate use. In these local storage places the ice cakes are generally kept in kitchen walk-in refrigerators, where floor space is available for the purpose, but more often they are held in improvised spaces in some basement or tunnel, or in the yard with a temporary wooden shed or a tarpaulin as a cover. In two cases the garbage refrigerator served the purpose of local storage!

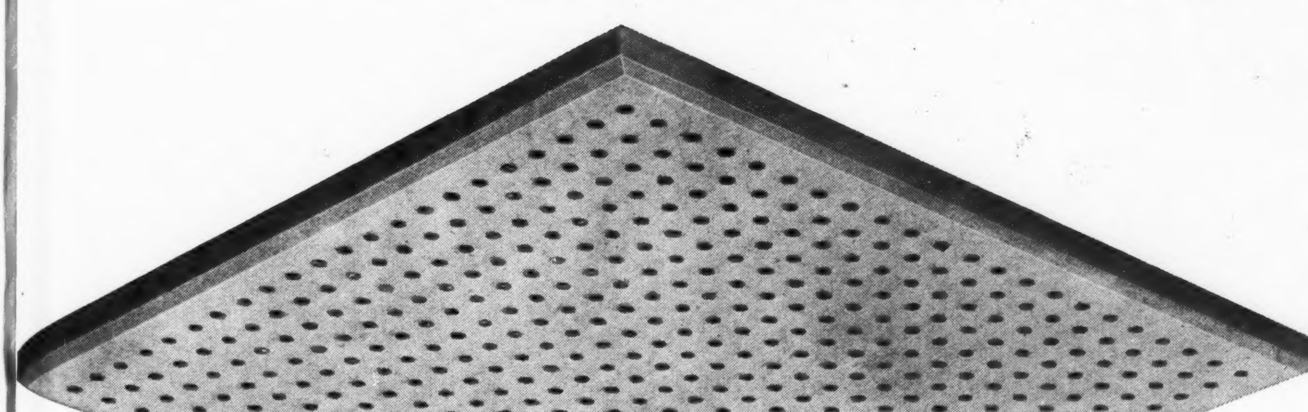
In most of the hospitals, ice in cake form is also delivered to the wards to be broken by ice pick for use in cooling the oxygen tents. In all the hospitals, some of the crushed ice has to be further broken down by means of mallet and canvas bag for ice bags and collars, for packs and for swallowing purposes.

It may be noted that everyone questioned who had anything to do with the steps involved in this process of providing ice said unhesitatingly that it is unsatisfactory from every angle and expressed wonder that nothing is being done to improve conditions.

Signs won't stop Noise Demons



But you can stop them with this ceiling



It's Armstrong's Cushiontone

IT TAKES MORE than warnings to quiet a noisy hospital. For the noise demons that really disturb your patients and wear out your staff come from necessary hospital activity. They're created by banging utensils, shrill bells, the echo of voices and footsteps.

Fortunately, these noise demons can be trapped — every time they appear—in an economical ceiling of Armstrong's Cushiontone*. The 484 deep holes in each 12″ square of this fibrous material absorb up to 75% of all noise that strikes the ceiling. Cushiontone is also a good light reflector and can be repainted many times without loss of acoustical efficiency.

Write for free booklet that gives all the facts. Armstrong Cork Company, 5705 Stevens St., Lancaster, Pa.

*REG. U. S. PAT. OFF.

MADE BY THE MAKERS OF ARMSTRONG'S LINOLEUM AND ASPHALT TILE

HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

Oil Keeps the Dust Down

A LAUNDRY process by which blankets and linens are treated with oil to reduce the spread of colds and other dust-borne infection was developed during the war and may soon be available for public use, according to a recent report from the American Institute of Laundering at Joliet, Ill.

Blankets and linens treated by the military process show no bad effects. They gained slightly in weight but at the same time proved warmer.

Most important, however, the report continues, is the fact that the dust provoking qualities of blankets and linens are reduced to a minimum. The absence of lint in the air cuts down the count of infectious air-borne bacteria by almost 100 per cent.

The process is simple and easily adapted for use in commercial or institutional laundries. Authority for its announcement was given by the Air Quartermaster General.

Technicians of the American Institute of Laundering suggest that the blanket oiling process may soon be made a part of the postwar laundering procedure for all bed clothes sent to commercial laundries. By the simple application of other modern methods, the power laundry can make all, or any, articles of apparel flameproof, mothproof, water-repellent, and mildewproof. With the release of the oiling process, consumers will be able to add "infection-retardant" to this list.

Consideration of blanket treatment was started during the early days of the war when respiratory diseases, coughs and colds began to spread through barracks and hospitals. Doctors knew that such infections were air borne or dust borne. They defined the problem: How to keep down dust.

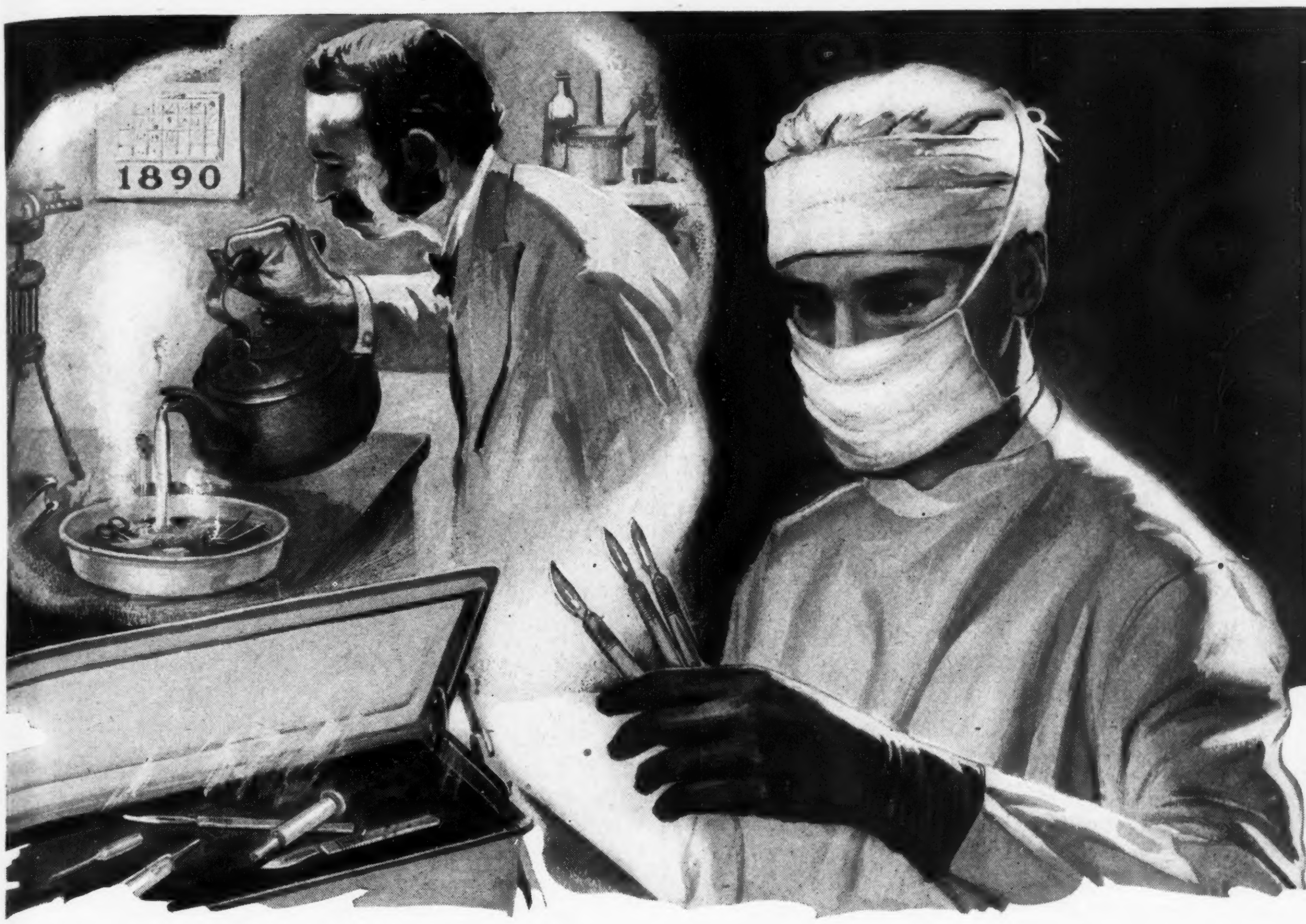
Research proved that the oiling of hospital and barrack room floors substantially reduced the incidence of colds among men. The next step was to prevent the linting of bed clothing.

Under the jurisdiction of the Commission on Air-Borne Infections, the project was conceived as a joint experiment for all American military men. After considerable trial, an oil formula was developed for the treatment of woolen blankets and linen in the final rinse of the laundry process. The oil, in an emulsion, was made up from liquid petroleum in whitish form and simply poured into the final rinse water.

Blankets and bed linens treated with the preparation gained imperceptibly in weight but were found to be warmer. No fire hazard was added. To one unacquainted with the fact that the bedding had been treated, the oiling was not apparent.

What did this mean in terms of health? The prevalence of colds and other respiratory infections was rapidly decreased. According to the report of investigators, the number of bacteria in the air was cut almost in half.

American reports showed that bacteria were reduced 97.5 during barrack room bed-making, when the dust usually flies. During periods when men were sweeping their quarters, the bacteria count, with an oiled floor and oiled bedding, was reduced 99 per cent.



THE EDGE OF DEPENDABILITY

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A. S. R. Blades rate high with exacting surgeons in the qualities that matter most: their just-right keenness, assured "feel" and perfect balance. *Uniformly* dependable, blade after blade.

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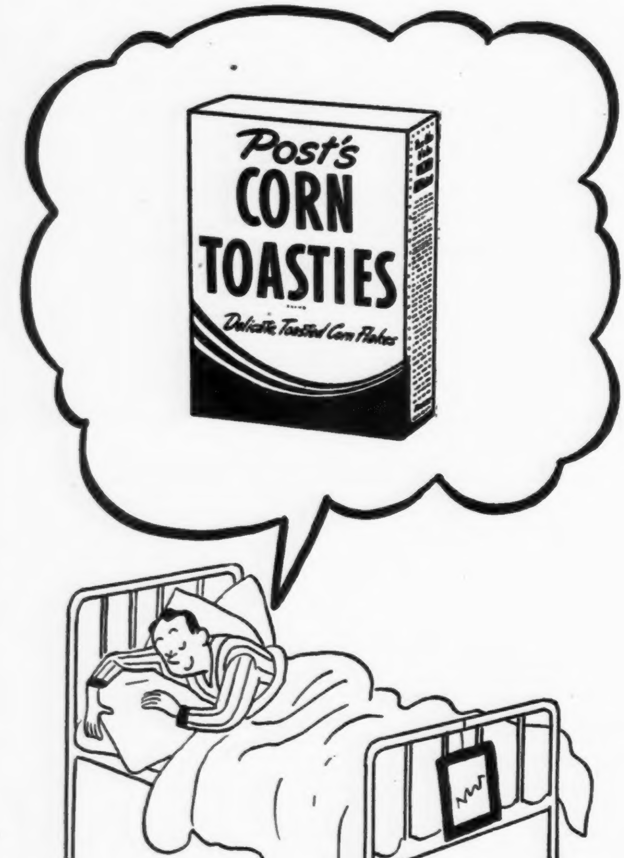
Surgeon's Blades and Handles

SURGICAL DIVISION, AMERICAN SAFETY RAZOR CORPORATION, BROOKLYN 1, NEW YORK

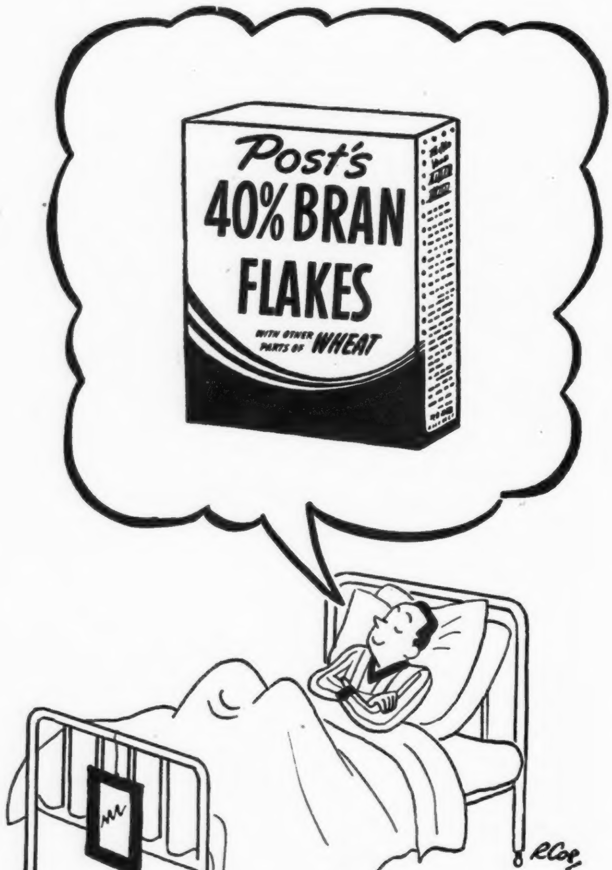
Makers of Fine Edges for Over Half a Century

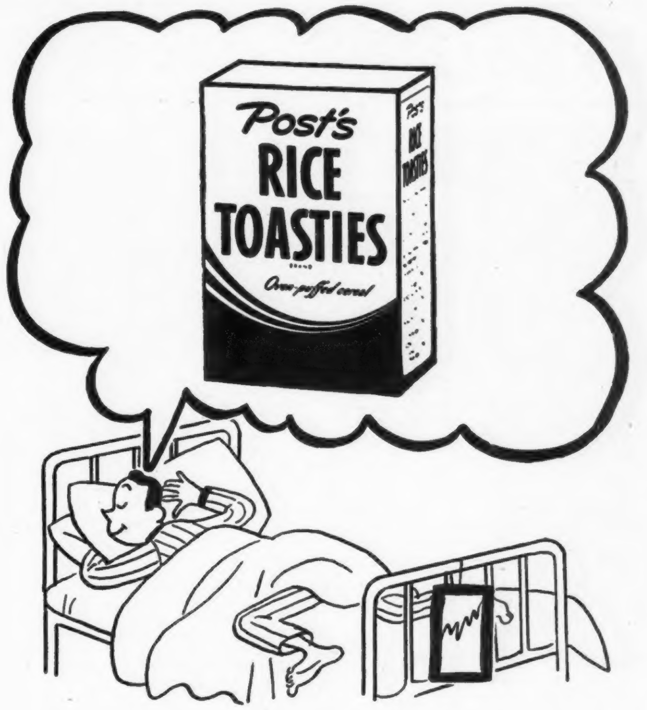
Six ways to make patients feel at home...

1. Serve 'em Post's Corn Toasties, one of the Post Cereals they have in their own homes. These honey-golden cereals are recommended on most standard diets; are preferred by most standard patients!



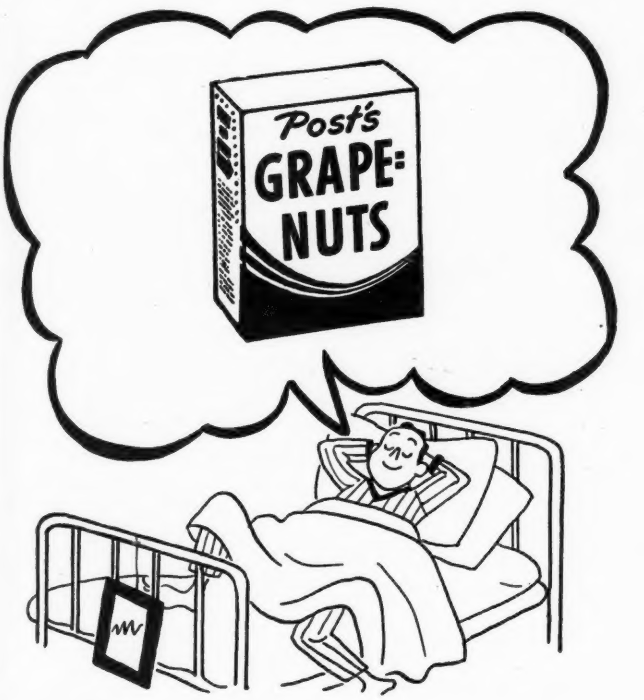
2. Try Post's 40% Bran Flakes. A good source of thiamine, niacin, and iron, this cereal has an altogether distinctive flavor, malty and hearty. And as long as the patients can have cereals anyway, give 'em the kind they eat at home!





3. And how about Grape-Nuts Flakes? These crisp, golden-toasted flakes are jam-packed with whole-grain nourishment and pack-jammed with nutty, wholesome goodness. Try them yourself!

4. Let 'em have a bowl of Post's Rice Toasties! This newest Post Cereal is already snap-crackling popular. It's jammed with whizzing B_1 energy, and downright, lip-smacking goodness!



5. Put Grape-Nuts on their trays! Sweet-as-a-nut Grape-Nuts have been breakfast favorites for years and years. Heaped with fresh fruit, covered with pasture-fresh cream or milk, *how could they help it?*

6. Here's number 6—the *original*—National Biscuit Co. Shredded Wheat, the crunchy biscuit that's absolutely unlike any other cereal. Put Post's Individual Cereals on any diet and just watch the response!

SERVE 'EM THE KIND THEY EAT AT HOME!... SERVE 'EM...

POST'S INDIVIDUAL CEREALS

ARMSTRONG X-4 PORTABLE BABY INCUBATOR

The Armstrong X-4 Baby Incubator is the only Baby Incubator tested and approved by Underwriters' Laboratories for use with oxygen.

1. **Low cost**
2. **Underwriter approved**
3. **Simple to operate**
4. **Only 1 control dial**
5. **Safe, low-cost, heat**
6. **Easy to clean**
7. **Quiet and easy to move**
8. **Ball-bearing, soft rubber casters**
9. **Fireproof construction**
10. **Excellent oxygen tent**
11. **Welded steel construction**
12. **3-ply safety glass**
13. **Full length view of baby**
14. **Simple outside oxygen connection**
15. **Night light over control**
16. **Both F. and C. thermometer scales**
17. **Safe locking ventilator**
18. **Low operating cost**
19. **Automatic control**
20. **No special service parts**
21. **Safety locked top lid**

IN offering you the Armstrong X-4 Portable Baby Incubator we stand firmly on the principle that we must provide a SAFE Baby Incubator, a LOW COST Baby Incubator and a SIMPLE Baby Incubator. That we have succeeded is evidenced by the fact that in less than a year, close to a hundred voluntary repeat orders have been received. It is now in use in 46 States as well as in Canada and Latin America. More and more it is being used, not only for the premature baby, but for any debilitated or under weight term baby. We sincerely believe you will like it.

If you will write us we will gladly mail you a descriptive bulletin. No salesman will call on you for the Armstrong Incubator must be fine enough and low enough in cost to sell itself. We believe wise supervision will appreciate this.

Exclusive Manufacturers and Sole Distributor in the United States

THE GORDON ARMSTRONG COMPANY

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HEADLINE NEWS

Hospital Admissions and Bed Capacity Increased in 1945

An increase in hospital admissions and a slight increase in bed capacity during 1945 were revealed in the twenty-fifth annual report of the A.M.A. Council on Medical Education and Hospitals. The report, prepared by Dr. F. H. Arestad and Dr. M. G. Westmoreland and published in the April 20 issue of the *Journal of the American Medical Association,* shows that a patient was admitted to a hospital in the continental United States every 1.9 seconds and that a live baby was born in a hospital every 16 seconds.

There were 16,257,402 admissions exclusive of out-patients and new-born infants in 1945, or an equivalent of 12.3 per cent of the total U. S. population as established by the 1940 census.

Compared with 1944, the number of hospital beds has increased from 1,729,945 to 1,738,944; the number of admissions, from 16,036,848 to 16,257,402; the number of patient days, from 475,607,484 to 512,915,155, and the number of hospital births, from 1,919,976 to 1,969,667.

The report represents 6511 hospitals registered by the American Medical Association, including 1156 hospitals approved for internships and residencies and 2625 accredited by the American College of Surgeons as meeting unconditionally its minimum requirements for general standardization. The number of hospitals totals 100 less than that reported in 1944.

Construction Order Violated

Washington, D. C.—Thousands of construction jobs started in violation of VHP-1, the veterans' housing-construction order, were halted by the compliance division of the Civilian Production Administration during the first two weeks after the order was issued, Morris S. Verner, compliance officer stated. Many builders started last minute excavations in an attempt to beat the deadline established in the order, Mr. Verner said, though there had been only one case of open defiance of the C.P.A. "The order was put into effect to provide materials for veterans' homes and other essential construction," he declared, "and we are going to do everything in our power to see to it that this high purpose is carried out."

Modern Hospital Survey Reveals Supply Outlook for Important Hospital Goods

Believing that a comprehensive view of the supply outlook today is something that every hospital administrator vitally needs, The Modern Hospital undertakes here to present latest information on the availability and delivery schedules of materials covering most of the major classifications of hospital purchases. To get this information, we sent hundreds of letters and telegrams and made telephone calls to manufacturers and distributors all over the country. Of course, not all sources could be covered; however, the listings presented here comprise the most complete and current picture that can be obtained of the hospital supply outlook. Together with The *Hospital Purchasing File,* which lists all the important sources of supply, this information provides all the background that is needed for intelligent purchasing procedure.

Hospital leaders with whom we have discussed this feature are enthusiastic about its usefulness. Only by carefully studying the facts given here, they say, can those responsible for hospital purchasing and, in fact, for hospital development as a whole plan wisely for the future.—The Editors.

Acoustical Materials.—Certain types of raw materials plentiful but labor conditions remain unsettled in some localities. Deliveries in one week to three months, depending on size and nature of order and source of supply. Metal-faced acoustical tile will not be available in quantity until fall because of the steel shortage.

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Anesthetic Equipment.—One manufacturer reports deliveries can be made in sixty days.

Bedpan Washers.—Delivery three to four months after date of order.

Builders' Hardware.—Deliveries slow. Strikes have delayed production in some plants.

Call Systems.—Delivery in one to three months from date of order for nurses' call systems, two to three months for doctors' paging and other signal systems calling for special engineering and layout.

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Dishes and Cups, Paper.—Moderate supply available for prompt shipment. Deliveries immediate to sixty days or

(*Continued on Page* 140.)

35 Per Cent Increase Charged to Subscribers of Michigan Blue Cross

A 35 per cent increase in rates charged to subscribers of Michigan Hospital Service was approved last month by David A. Forbes, state insurance commissioner, to cover increased hospitalization costs. Under the new rate schedule, ward service rates for a single person went from 80 cents to $1.12; semiprivate service, from $1 to $1.40; ward family service, from $2 to $2.60, and semiprivate family service, from $2.40 to $3.10.

The increases were made necessary by sharply rising hospital costs, it was explained. During 1945, Michigan Hospital Service suffered a net loss of $800,000, the insurance commissioner pointed out, bringing the corporation's surplus down to $300,000 at Jan. 1, 1946.

The insurance department is considering a proposal to change the formula under which 144 hospitals are reimbursed for service to subscribers, Mr. Forbes said. "It is the concern of the insurance department to make sure the public pays enough into the plan to cover these costs." he declared.

Black Market in Drug Probed

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Provisions of Health Insurance Bill Hotly Argued at Senate Hearings

By EVA ADAMS CROSS

WASHINGTON, D. C.—Hearings beginning in early April before the Senate Education and Labor Committee on the Murray-Wagner-Dingell national health insurance bill had by April 19 contributed numerous arguments both for and against the legislation. S. 1606 covers three of the President's five points in his recommendation to Congress last fall for a national health program: expansion of public health, maternal and child health services; more adequate funds for education and research, and a system of prepaid medical costs.

Many of those testifying approved the bill in part. It was Title II, providing for national health insurance protection, which brought on the fireworks. Senator Wagner in an opening statement declared that health insurance is not socialized or state medicine; that no regimentation of doctors, hospitals or patients is implied in the plan. But words such as *regimentation, politics, propaganda, socialistic* and *communistic* were tossed back and forth during the hearings.

Proponents of the bill had an impressive line-up of those favoring the legislation in whole or in large part. Among these supporters were: the U. S. Public Health Service, as represented by Dr. Joseph W. Mountin; two major church groups; Watson B. Miller, Federal Security Administrator; Harold L. Ickes, executive chairman of the Independent Citizens' Committee of the Arts, Sciences and Professions; the Physicians' Forum; the National Medical Association, composed of some two thirds of the approximately 4000 Negro physicians in this country; the American Association of University Women; Dr. Allan M. Butler, associate professor of pediatrics, Harvard Medical School; the joint subcommittee on health of the National Planning Association; the Southern Conference for Human Welfare; Arthur J. Altmeyer, and New York's former mayor, Fiorello H. La Guardia.

Leading off the opposition were: Senator Taft of Ohio; the Association of American Physicians and Surgeons; the National Physicians' Committee for the Extension of Medical Services; Dr. Walter V. Kennedy, president of Indiana Mutual Medical Care, Inc., and Dr. Lowell S. Goin, who upheld the American Medical Association's opposition.

Dr. Joseph W. Mountin, appearing for Surgeon General Thomas Parran, told the committee that the U.S.P.H.S. strongly urges the establishment of a national health program, as advocated by the President and considers S. 1606 as a vehicle to put the major elements of the President's health program into effect. He gave unqualified approval to proposals for expanding medical research and for extending opportunities for professional education.

Dr. Lowell S. Goin, opposing the bill, dwelt on the complexity of government controlled compulsory health insurance plans and the impossibility of their composing a "neat and effective solution" to the medical and health needs of the country.

Voluntary health plans will, if given the opportunity, do the job and do it better than government controlled plans can do, insisted Doctor Goin. Yet, Doctor Mountin declared that although voluntary health insurance groups have demonstrated that the principle can be applied to the economic problem of sickness, they have also revealed the weaknesses of voluntary health insurance and its inability to meet health needs on a national scale.

Crosby, Whitecotton Named to TMH Board

Dr. Edwin L. Crosby Jr. and Dr. G. Otis Whitecotton have accepted appointments to the editorial board of The MODERN HOSPITAL, it was announced at the magazine's offices in Chicago May 1. Doctor Whitecotton, who left the University of Chicago Clinics recently to become director of Alameda County Institutions at Oakland, Calif., will serve on the editorial board as an adviser on governmental hospitals. Doctor Crosby, who is director of Johns Hopkins Hospital, will be an editorial consultant for the magazine.

News of Four Meetings to Be Reported in June

As this issue of The MODERN HOSPITAL goes to the printer, the Midwest Hospital Association is meeting in Kansas City, Mo., Southeastern Hospital Conference in Jacksonville, Fla., and the Hospital Association of Pennsylvania in Philadelphia. At the same time, hospital leaders of Illinois, Michigan, Wisconsin and Indiana are putting the finishing touches on the program for the annual Tri-State Hospital Assembly in Chicago May 1-3. Full reports of the news from these important meetings will be brought to our readers in next month's magazine.—ED.

Blue Cross Membership Reaches 21,500,000 During First Quarter

Membership in Blue Cross plans reached 21,500,000 in the first quarter of 1946, C. Rufus Rorem, director of the American Hospital Association's Blue Cross commission, reported in a statement to the Senate Labor Committee in Washington April 22. First quarter membership gains totaling 1,370,000 made this the largest enrollment quarter in Blue Cross history, Rorem stated at the committee's hearings on the Wagner-Murray-Dingell Bill.

Mr. Rorem and John R. Mannix, director of Chicago Blue Cross and commission chairman, presented a four-point health program embracing:

1. Tax-paid medical and hospital care for relief clients and other indigents.
2. Government aid in the construction of hospitals and clinics in areas of indicated need.
3. Grants-in-aid to approved state voluntary health plans also supported by contributions from participants.
4. Pay-roll deductions to enable federal employes to join voluntary prepayment health plans.

As of April 1, 1946, Mr. Rorem reported, the three largest Blue Cross plans were New York, with 2,344,000 members; Massachusetts, with 1,637,000, and Michigan, with 1,242,000. Largest membership gain reported for the first quarter of the year was in Massachusetts, which added 205,000 members.

"Your Hope for Health" Is Hospital Day Slogan

Hospital surveys, licensing laws, prepayment plans and new design and construction features are indications that public confidence in hospitals is merited, Dr. Peter D. Ward of Minneapolis, president of the American Hospital Association, said in a National Hospital Day statement.

"The public has become more hospital minded," Doctor Ward declared. "Increased appreciation of hospitals is due largely to the progress of medical science in the control of disease, progress that in the last 150 years has doubled the average number of years a man may expect to live."

"The hospital — Your Hope for Health," is the slogan hospitals have adopted for the 1946 celebration of National Hospital Day, May 12, Doctor Ward said. Hospitals are now facing the greatest challenge in their history in supplying adequate care to the largest patient load they have ever been called on to handle, he concluded.

Surplus Medical and Surgical Supplies Offered at Fixed Prices

By EVA ADAMS CROSS

WASHINGTON, D. C.—For the first time currently available surplus medical and surgical equipment and supplies from all the regions of the War Assets Administration, Consumer Goods Division, are offered at fixed prices through the *Surplus Reporter* of April 11. The total quantity of each item available in all regions is noted. This new arrangement of offerings enables all classes of eligible buyers to select and buy goods directly by placing orders with the regional offices serving the states in which the goods are located.

Orders from nonprofit hospitals eligible for the 40 per cent discount from the prices quoted in this *Surplus Reporter* must be submitted in accordance with procedures prescribed by the Federal Security Agency.

Some 14 pages of this issue of the *Surplus Reporter* are given to listings of hospital and laboratory equipment and supplies offered for sale, 51 pages to medical, surgical, dental, professional and scientific equipment and 17 pages to drugs and cosmetics.

A recent special report to the President declared that the government must speed disposals of surplus property faster than is contemplated by the present program of Lt. Gen. Edmund B. Gregory, War Assets Administrator. To ease the shortage of consumer goods and to curb inflation, a vigorous disposal policy is clearly called for, said the report. More sales outlets are needed, more flexible methods of disposal are required.

The report was prepared by Howard Bruce, Maryland banker and business man, who was appointed by the President to study methods for expediting disposal of war surpluses.

Representatives of 21 national educational institutions early in April submitted recommendations for facilitating disposal of surplus property to educational and public health institutions by the War Assets Administration. The educators objected to the price policy set forth in SPA Regulation 14, to the short period of offering to priority claimants and to the minimum quantities allowed for purchase. The recommendations have been taken under advisement by the War Assets Administration.

Penicillin Production Up; Streptomycin Supply Still Limited

By EVA ADAMS CROSS

WASHINGTON, D. C.—Production of penicillin is currently running at 300 per cent of the December 1945 rate, the Civilian Production Administration reported April 9. However, production of streptomycin is still too low to meet even military needs although 32 per cent was allocated during April for civilian and research purposes.

Penicillin estimated to be available in April was approximately 2,178.175 billion units compared with 737.55 billion units last December. In view of the large production increase and the fact that the heaviest seasonal demand for the drug for respiratory diseases has passed, C.P.A. has increased allocations for export to a new high level to help satisfy the pressing world-wide need of the drug.

Streptomycin availability for April was estimated at about 29,900 grams compared with about 27,260 grams in March. The production rate is not yet on a commercial scale and is far too low to meet military requirements. The limited supply now available is being distributed to the military services, to other government agencies and to the National Research Council for a research program financed by the streptomycin producers. Civilian appeals can be granted only from the supply made available under the research program.

The American Pharmaceutical Association has asked pharmacists who receive inquiries from physicians about streptomycin to make clear these four facts:

1. Streptomycin is available only for clinical trial until further notice.
2. All requests for the drug must be made of Dr. Chester S. Keefer, Evans Memorial Hospital, Boston. (Telephone, Kenmore 9200.)
3. Requests are to be submitted only by physicians, who should supply complete clinical data on their cases when applying and be willing to submit adequate records on the results of treatment.
4. Appeals for streptomycin should be restricted to infections that are not susceptible to the action of sulfonamides, penicillin or other therapeutic agents.

The *Journal of the American Pharmaceutical Association* for April emphasized that the drug cannot be obtained from producers or government agencies and expressed the opinion that general distribution is probably many months away.

Cedars of Lebanon Picketed by Members of Nurses' Union

Picketing of the hospital by nurses in uniform highlighted efforts of the Registered Nurses' and First Aid Workers' Union (A. F. of L.) to obtain recognition as bargaining agent for eligible employes of the Cedars of Lebanon Hospital, Los Angeles, last month. Picketers, including half a dozen nurses employed in the hospital, marched in a circle in front of the hospital's main entrance every afternoon for several days, carrying signs protesting the hospital's refusal to deal with the union. There was no strike of hospital employes during the disturbance.

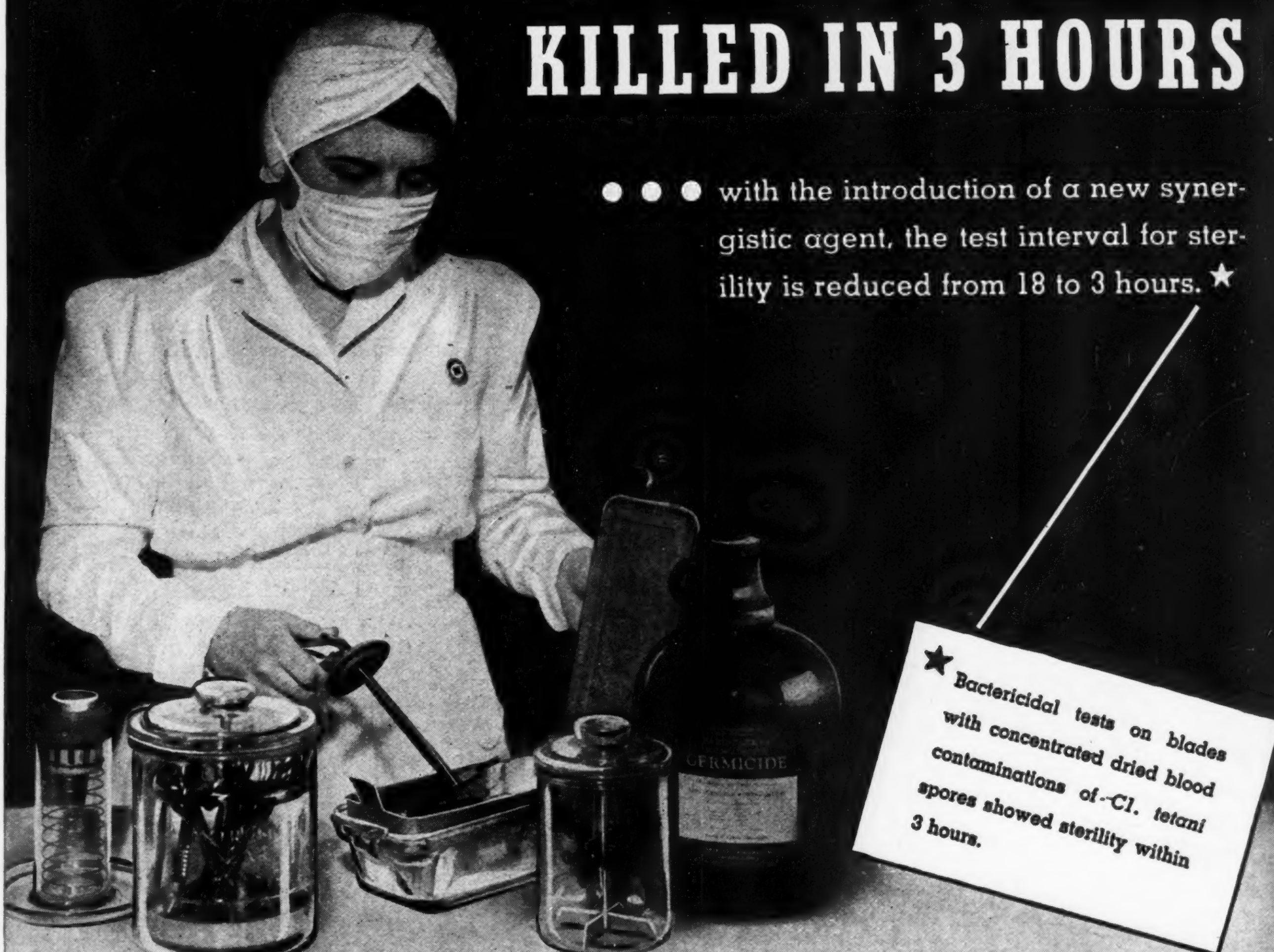
Demonstration Repudiated

Hospital and nursing officials declared that the union represented only a fraction of the hospital's employes, that most of the nurses on the staff were not in sympathy with the picketers and that the California State Nurses' Association ıd approved wages and working conditions in the hospital and had no part in the protest. Staff nurses were described as "embarrassed and indignant" about what was termed an "unprofessional public demonstration."

Claiming a majority of the 200 hospital employes in eligible classifications, union officials said the hospital refused to recognize the group and would not even meet to discuss grievances. They emphasized that the workers were picketing during off hours, not striking.

"This hospital is not opposed to unionism," Supt. Emanuel Weisberger replied to union charges, "but we do object to the fact that this is the only hospital in Los Angeles which has been asked to recognize a nurses' union. With regard to salaries and working conditions we are governed by the recommendations of the California State Nurses' Association. Whatever practice is adopted generally in this area will be wholeheartedly acceptable to the trustees of this institution."

Nurses, janitors, ward and kitchen aids at St. Luke's Hospital, Seattle, are included in a contract between the hospital and the Seattle local of Building Service Employes International (A. F. of L.), according to a news service bulletin. First contract of its kind in Seattle covering all the employes of a medical institution, the arrangement provides a forty hour working week, with time and a half for the sixth day and double time for the seventh. Wages are the highest paid in any institution in the city, the report says.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★ Bactericidal tests on blades with concentrated dried blood contaminations of Cl. tetani spores showed sterility within 3 hours.

Urgency Certificates Issued to Producers of Critical Materials

WASHINGTON, D. C.—The Civilian Production Administration announced April 5 that it had created urgency certificates to be issued to producers of critically scarce products that will give such producers first call on stocks of surplus equipment. They will have priority over any other class of buyers of government surplus equipment. Certificates will be issued only for equipment needed by producers of the commodities classified as critical in Schedule 1 of PR-28.

This schedule now includes: certain types of coal in specified areas; coal mining machinery; clay building products; clay building products machinery; streptomycin; penicillin; malleable and gray iron castings, including cast-iron soil pipe and cast-iron radiation; lumber; logs; pulpwood; softwood veneer; softwood plywood; mill work; concrete building products; machinery and equipment; titanium dioxide; rosin; fractional horsepower A.C. motors, and electrical high-silicon sheet steel.

Set Up Coordinating Committee

WASHINGTON, D. C.—The Civilian Production Administration has organized an inter-agency Construction Coordinating Committee made up of representatives of a number of federal agencies, according to an announcement April 2. The action was taken to place federal construction projects under the same standards of essentiality as apply to private buildings. The committee will review and pass on all government construction programs which might interfere with the Veterans Emergency Housing Program. The agencies represented are: the War Department, the Navy Department, the Departments of the Interior, Commerce, Agriculture, the Veterans Administration, the Federal Works Agency, National Housing Administration and War Assets Administration.

Miller Heads V.A. Division

WASHINGTON, D. C.—Dr. James G. Miller, Cambridge, Mass., has been assigned as chief of the Veterans Administration's new division of clinical psychology in the neuropsychiatric service, according to an announcement April 9. Doctor Miller, who was on the personality assessment board of the Office of Strategic Services, holds an M.D. and a Ph.D. from Harvard. He will direct the work of all clinical psychologists in V.A. hospitals and mental hygiene clinics. When the program is in full operation, an estimated 600 psychologists will be aiding veterans to recover.

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Jersey Hospitals Make Progress With Proposed Medical Center

Development of a medical center in the Oranges and Maplewood, N. J., involving upward of an estimated $3,000,000 over the next ten years is progressing rapidly. The first step will require $925,000 to cover the cost of erecting a new 70 bed unit for the New Jersey Orthopaedic Hospital and Dispensary adjacent to Orange Memorial Hospital and conversion of Orthopaedic's present 41 bed building into a new 70 bed convalescent hospital.

York and Sawyer, hospital architects, New York City, have been retained to advise with a special "medical center development committee" representing the boards of both hospitals, which has been appointed to survey and plan the broad medical center program in detail. The committee is also being guided by a recent study by Dr. C. W. Munger.

Besides the initial step calling for the new convalescent hospital and closer physical affiliation and coordination between Orange Memorial and New Jersey Orthopaedic hospitals, the medical center program will ultimately include development of a number of existing special departments and services.

In addition, the development committee's survey will include other fields of medicine and surgery in which trends in practice and new discoveries suggest the need for establishing various new departments or services. In this connection two projects to command attention will be a department of psychiatry for the treatment of mild mental illness, and a department of geriatrics for the diagnosis and treatment of the illnesses of old age. Special investigation will also be made of the greater contribution which the medical center, through the new Orthopaedic Hospital unit, can make in the treatment of infantile paralysis.

The development committee will also study the services which the medical center can offer to practitioners and nurses located in that section of New Jersey in terms of postgraduate training, "refresher" courses and extension clinics. Although Orange Memorial is an accredited hospital for intern training, the hospital would seek medical school cooperation in working out a plan of advanced study and clinics for practicing physicians and surgeons.

Consideration also will be given to the need, which is reported to exist in communities and regions of North Jersey that have no hospital facilities, for cooperation in servicing smaller hospital units in localities which cannot support the usual general hospital.

Group Health Plan Extends Service to Nongovernment Members

WASHINGTON, D. C. — The Group Health Association on March 31 extended its medical and hospital services to the first group of persons outside the federal government. The association is seeking a membership of 35,000 by next year. It now has 9000 federal employe members. Harry J. Becker, president of the association, has announced that the organization will admit members regardless of race or color.

Melvin Dollar of the Bureau of Public Health Economics, University of Michigan, will serve as executive secretary. In addition, Dr. Paul W. Spear, internal medicine specialist at Johns Hopkins University, has been added to the staff.

Hospital Ship to U.S.P.H.S.

WASHINGTON, D. C.—A 300 bed hospital ship that was turned over to the U. S. Public Health Service April 17 may be anchored in the Potomac for the treatment of venereal disease patients from the District of Columbia, Maryland and Virginia.

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Nurses Present Personnel Measures at Iowa Meeting

Personnel recommendations presented to the Iowa Hospital Association by the State Association of Registered Nurses at the annual hospital meeting in Des Moines April 15-17 were approved in principle but referred back to the nursing group for further study and revision. The recommendations set forth in detail the wages, working conditions and personnel practices which the nurses felt should be the minimum for all institutions employing graduate nurses.

Paul Hanson, recently returned to his position as administrator of the Iowa Lutheran Hospital, Des Moines, after three years' service in the Medical Administrative Corps, U. S. Army, was made president-elect of the hospital association, and Dr. Charles F. Obermann of Cherokee State Hospital, Cherokee, took office as president. The meetings covered discussions of Blue Cross, medical prepayment plans, professional and administrative standards in the hospital, veterans' care, hospital planning and community service. The state associations of medical record librarians, dietitians, occupational therapists, pharmacists, x-ray technologists and anesthetists were also in Des Moines for their annual meetings.

"Because the nurse has proved her value to society and makes an important contribution to the welfare of any community, she has a right to expect that her efforts will provide the means to preserve her self-respect, protect her health, advance her professional career and improve her station in life," the nurses' association declared in presenting recommendations calling for minimum salaries of $150 a month for graduate nurses; a forty-eight hour week without broken shifts except under extraordinary circumstances, and liberalized sick leave and vacation privileges.

After considerable discussion of the proposals, the hospital association voted to approve the recommendations in principle as "a promising start toward solution of the problems confronting hospitals and nurses" but to refer the statement back to the nurses for further study, with particular emphasis on the inclusion of some definition of the responsibility of nurses toward the needs of patients.

In a talk on professional standards, Dr. Hugo Hullerman of the American Hospital Association urged that more care be taken in appointing surgeons to hospital staffs. Proper qualifications are not insisted on in many institutions, Doctor Hullerman stated, and there must be an intensive effort to raise standards and keep them up. Doctor Hullerman also advocated tight licensing laws and minimum standards for hospital governing boards. Everett Jones, vice president of The Modern Hospital Publishing Company, talked on administrative standards.

Officers of the association elected for the coming year include: first vice president, Sister Mary de Lellis, Mercy Hospital, Oelwein; second vice president, Harold Smith, University Hospitals, Iowa City; secretary, Clara Hendrickson, Iowa Lutheran Hospital, Des Moines; treasurer, Lilyan Zindell, Atlantic Hospital, Atlantic; trustees are: R. A. Nettleton and T. P. Sharpnack, Des Moines; Rubie M. Carlson, Waterloo, and Lillian P. Carey, Ottumwa.

Surgical Items for Sale

WASHINGTON, D. C.—Surplus surgical items were announced for sale between April 19 and May 13 by the War Assets Administration. Samples may be examined by prospective purchasers in any of the 33 regional offices. Close to a million of these items are to be sold. Their original cost to the government was more than $150,000. These surgical supplies are: surgeons' gloves, operating knives, handles, blades, plates, screws, Lane and bone screw drivers.

Survey Reveals Outlook on Hospital Goods

(*Continued From Page* 129.)

longer for a few items in heavy demand. Demand is expected to exceed supply at least during the first six months of 1946.

Electronic Air Cleaners.—Four to ten weeks for delivery of priority-rated orders; five to twelve weeks for unrated orders. Permanent or disposable unit filters, deliveries in three weeks.

Elevators.—Equipment for authorized building projects starting now should be available for installation without delay by the time building is completed. Additional equipment for modernization of existing buildings cannot be furnished promptly. Delivery date depends on type and size of installation.

Emergency Lighting Systems.—Delivery in four to six weeks from date of order.

Fans and Blowers.—Six to ten weeks from date of order for standard models.

Flooring.—Manufacturers still on an allotment basis to customers since demand far exceeds supply. Average deliveries, four to six months for customers with allotments.

Filters.—Manufacturers well stocked with materials and able to fill orders within reasonable length of time, normally thirty to forty-five days.

Flake Ice Machines.—Prompt delivery on standard small units.

Floor Machines. — Production has been delayed by strikes. Delivery of "utility sizes" now thirty to sixty days; large sizes require from four to eight months.

Food Service Accessories, Paper.—Deliveries of napkins and crêpe tray covers running thirty to ninety days on small emergency orders. Supply of specific items varies widely from manufacturer to manufacturer.

Food Service Equipment.—Commercial cooking equipment can be delivered six months after date of order. Situation is improving rapidly, however, in the opinion of one large manufacturer.

Food Tray Trucks, Heated.—Standard models of stainless steel construction can be delivered in six to ten weeks. Manufacturers' situation is improving so that four week delivery should be possible some time during the second quarter of the year.

Laboratory Furniture.—Wood cabinets and furniture can be delivered in about ninety days. Steel desks, chairs, filing cabinets, shelving and other items, from four months to six or eight months, depending on exact nature of order.

Lighting Fixtures. — Manufacturers progressing slowly against large volume of back orders. Future deliveries unpredictable because of uncertainties of suppliers of steel and electrical devices; now four to six weeks on most items. Delivery of fluorescent lighting fixtures, four to five months from order date.

Metal Lockers and Cabinets.—Delivery, four to eight months from order date.

Movie Projectors. — Large backlogs of orders piled up during the war are now being liquidated; 16 mm. sound projectors now take three to six or seven months after date of order for delivery.

Office Furniture.—Three or four to six months after date of order before delivery of most metal desks, chairs and filing cabinets can be made. This material is likely to remain scarce for the rest of the year.

Oil Burners.—Inability to get electric motors is manufacturers' chief problem. Labor difficulties hamper some. Reports indicate delivery of burners for high pressure boilers may be as prompt as four weeks after order in some instances. Other lines run up to delays of four or five months.

Operating Lights. — Delivery from thirty days to four months, depending on nature of order and source of supply.

Operating Tables. — Delivery from five to seven months, depending on nature of order and source of supply. Obstetrical tables may be delivered in three months; fracture tables take about five months.

Plumbing Fixtures. — Baths, sinks, lavatories and water closets, three to four months after order.

Plumbing Fixtures, Brass.—Delivery from four to six months after order reported by one manufacturer. Many unwilling to make any commitments on deliveries. Small emergency orders for replacement and repair may be furnished in five or six weeks.

Pumps.—Poor delivery situation generally. One manufacturer reports four to six weeks' delivery on boiler feed water pumps and other power plant pumps.

Refrigerators.—Walk-in and reach-in units are available; delivery time gets

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longer as size of unit decreases, with approximately a year required for fractional horsepower sizes. Delivery of deep-freeze units varies with the type and size of unit required, from promptly filled orders for the smaller boxes to a twelve month schedule for much larger sizes.

Silver, Flatware.—Two years or more will be needed to catch up on the backlog of orders. Certain items can be shipped ninety days after date of order; others will take six months or more to deliver.

Steam Boilers.—Twelve to sixteen weeks is the current delivery time for large cast-iron boilers.

Sterilizers.—Delivery, three to four months after date of order.

Stokers.—Good delivery on all standard sizes of domestic and commercial stokers. Delay develops when installations call for other than standard models. All information subject to change as industry is affected by strikes and unrest among suppliers of parts and materials used in stoker manufacture.

Temperature Control Systems.—Immediate delivery on some types of regulators. Generally about thirty days for small installations and three to four months for larger ones. Complete temperature control systems for installation in new buildings take four to eight months to deliver, depending on the size and nature of the installation.

Textiles.—In general, the textile lines are expected to remain scarce, at least for the remainder of this year, though there are wide variations from one item to another. Towels, especially face towels, appear to be more plentiful, while sheets and pillowcases remain on an allotment basis.

Toilet Tissue and Paper Towels.—There is still considerably more demand than can be met fully on fast delivery, but most mills and distributors are in position to supply fill-in quantities promptly.

Vacuum Cleaners.—Delivery schedules determined by availability of electric motors to manufacturers. Generally, two to six months are required after order, depending on the size of the unit and type of motor required. Best delivery on small units with standard three-phase motor.

Wall Washing Machines.—Hospitals given preference with most manufacturers. Limited number of units available in from one to three months.

Water Softeners. — Deliveries practically normal, though scarcity of parts may occasionally delay orders. Generally, installation of equipment built to fit the hospital's individual requirements may be made thirty to forty-five days after the date of the order.

Amend Set-Aside Order Governing Fabrics for Second Quarter

WASHINGTON, D. C.—M-328B, the order governing set-asides of fabrics to meet the needs of doctors, nurses, dentists and hospital workers for washable service apparel, was amended April 3 to meet the second quarter program. A 6 per cent increase in the amount of fabrics to be set aside in the next three months for the government's low cost clothing program was announced by C.P.A. The major part of the increased set-aside will be in cotton fabrics.

Priority assistance will be granted manufacturers of such materials as poplins, drills, print cloth and Class "A" sheetings.

Schedule C to M-328B as amended April 3 has also been issued. Schedule C gives the cotton fabric set-aside for the second quarter of 1946 and the Preference Rating Schedules governing nurses' uniforms and doctors', interns' and orderlies' gowns, suits and coats.

Urges Aid to Handicapped

WASHINGTON, D. C.—Dr. Howard A. Rusk, originator of the AAF convalescent training program, urged civilian aid to the handicapped in an address here April 8 at the annual meeting of the Washington Instructive Visiting Nurse Society. The total rehabilitation need, of which war-incurred disability is only a part, involves some 23,000,000 persons, he said. If civilian hospitals and communities as a whole would set up rehabilitation centers, the effort would pay off economically and in the field of humanity, Doctor Rusk asserted.

Endres Is Named President-Elect of Ohio Hospital Group

D. A. Endres of the Youngstown Hospital was named president-elect of the Ohio Hospital Association at the thirty-first annual meeting in Columbus, April 1-4. Van C. Adams, Jewish Hospital, Cincinnati, took office as president for the coming year, succeeding Lee S. Lanpher, Lutheran Hospital, Cleveland.

Planning the new hospital was the subject for discussion on the first day of the meeting. Among those who took part in the program were Dr. Vane M. Hoge of the U. S. Public Health Service, who talked about the effects on planning of the hospital's steadily increasing recognition as the center of community health activities; Carl A. Erikson, Chicago architect, who related medical and scientific progress to trends in hospital building and the selection of materials, and Marshall Shaffer, chief architect for the hospital facilities section, U. S. Public Health Service.

"Let's study the anatomy of the hospital building," Mr. Erikson suggested in his talk. "There are no important changes in sight for the hospital skeleton or general structure. There may, however, be some important changes in the skin. For example, we may see thin, 4 inch insulated aluminum walls instead of the 12 to 14 inch masonry we are accustomed to. There may also be some improvement in the building's arteries, such as pipes and wiring." New materials and processes, especially in the plastics and electronic fields, may bring many more changes in hospital buildings, Mr. Erikson concluded.

Hospitals of all sizes in all communities must eventually have departments of physical medicine, Dr. Shelby Gamble of Columbus told association members at a general meeting in which various hospital departments were considered in turn. Physical therapy is becoming more and more important in the management of all kinds of medical problems, Doctor Gamble said, and ultimately physicians and the public will make this demand on hospitals.

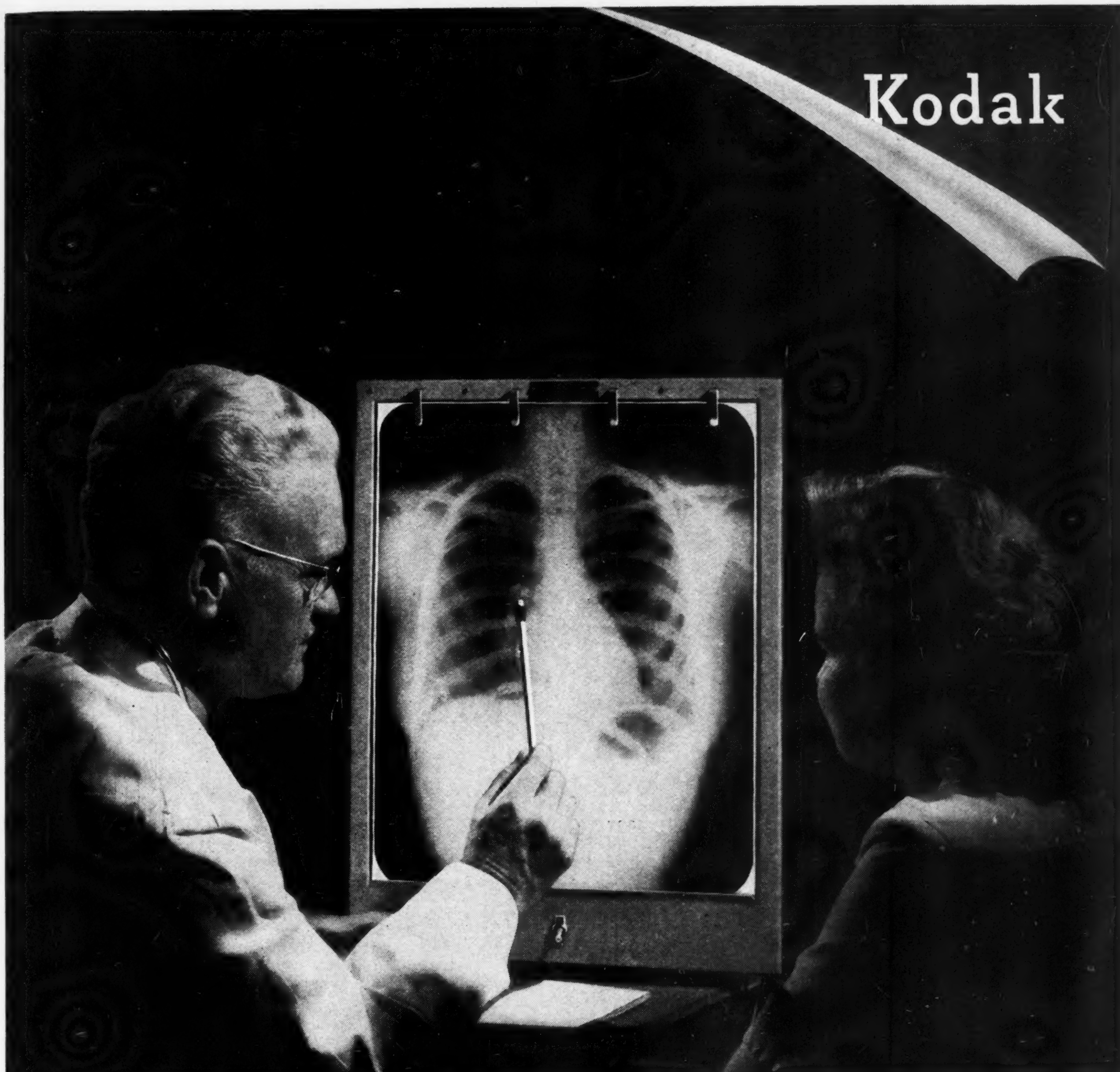
Other speakers on this program were Dr. Fred Carter, St. Luke's Hospital, Cleveland, who talked on anesthesia, radiology and pathology; Dr. R. H. Bishop Jr., University Hospitals, Cleveland, hospitalization insurance; Dr. M. F. Steele, Christ Hospital, Cincinnati, medical records; D. A. Endres, Youngstown, hospital finance, and Walter Frazier, pharmacist at Springfield City Hospital, pharmacy.

In addition to Mr. Endres, officers elected by the association were: first vice president, James W. Stephan, Aultman Hospital, Canton; second vice president, Sister Mary Alfreda, Mt. Carmel Hospital, Columbus; treasurer, Rt. Rev. Msgr. M. F. Griffin, Cleveland; delegates, Guy J. Clark, Cleveland, and Dr. M. F. Steele, Cincinnati. Lee S. Lanpher of Cleveland and Mary C. Schabinger of Detwiler Memorial Hospital, Wauseon, were named alternates. W. L. Benfer and O. K. Fike were elected chairmen of the northwestern and southwestern district councils, respectively.

Amend M-317 and M-317A

WASHINGTON, D. C.—New distribution controls on cotton fabrics through amendment to M-317 and M-317A were announced by the Civilian Production Administration April 1. Under the revised regulations, producers of specified industrial types of cotton fabrics will set aside a proportion of their second quarter output to meet vital industrial and agricultural requirements.

The fabrics include hose and belting duck, enameling duck, osnaburgs, coarse and medium sheetings, drills, twills, sateens, jeans and the standard types of print cloth. Among other things, such fabrics go into the manufacture of medical and surgical supplies, rubber tires, vehicles, furniture and construction machinery.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Incorporation Papers Granted to A.M.A. Medical Care Group

Incorporation papers for Associated Medical Care Plans, the American Medical Association's "holding company" for prepayment medical plans sponsored by state medical societies, were issued in April by the secretary of state of Illinois.

Under the authority granted by the state, the new corporation may "promote establishment and operation of such nonprofit, voluntary medical care plans throughout the United States and Canada as will adequately meet the health needs of the public and preserve and advance scientific medicine and the high quality of medical care rendered by the medical profession of the two countries." The corporation, it was explained, will coordinate methods of operation and actuarial data for the various state plans, which will function autonomously.

The A.M.A.'s commission on prepayment medical plans, which is described as "in effect, the new corporation's board of directors," will undertake the following duties, an announcement from the association offices in Chicago states:

1. Compilation and distribution of statistics covering experience on financial operations and medical service.
2. Consultation and information services for existing and projected state medical plans.
3. Public education concerning the scope and significance of medical care plans operating under medical society auspices.
4. Coordination of methods to make possible reciprocity of enrollment and benefit payments among the several plans.

Officers of the new corporation are: president, Dr. F. E. Feierabend, Kansas City, Mo.; vice president, Dr. William M. Bowman, San Francisco; treasurer, Dr. Norman M. Scott, Clinton, N. J.; secretary, Jay C. Ketchum, Detroit.

V.A. Starts Dental Program

WASHINGTON, D.C.—A dental training program, similar to the "deans' committees" which now select full-time resident physicians and part-time medical consultants for V.A. hospitals, will link the Veterans Administration and all of the 40 Class A dental schools in the United States, Dr. Paul R. Hawley, V.A. chief medical director, has announced. Dr. Vern D. Irwin, former director of the division of dental health in the Minnesota Department of Health, will establish the dental program.

Surplus Quotas Set by W.A.A.

WASHINGTON, D. C. — The national sales quota for surplus property in the second quarter of this year is $1,273,000,000, the War Assets Administration announces. The amount represents the reported cost of goods and is the total of separate quotas for consumer goods, which is $751,100,000, and for capital and producer goods, which is $521,900,000.

Under a new quarterly quota system, each of the 33 regional W.A.A. offices will have individual sales quotas for the type of goods it sells. Offices will then be able to measure actual disposals in their regions against the quota goals for April, May and June.

Named to V.A. Hospital Staff

WASHINGTON, D. C.—Dr. Rutherford B. Stevens of Washington, D. C., has been appointed resident psychiatrist at Winter General Hospital, Topeka, Kan., the Veterans Administration announced April 8. Doctor Stevens is the first Negro doctor appointed to the staff of a V.A. hospital not exclusively for Negro veterans. He is a graduate of Howard University and has served five years in the Army Medical Corps. He leaves the Army with the rank of Major.

Mills Emphasizes Administrators' Need of Formal Training

The growing complexity of hospital operation and the important place of hospitals in community life today make it necessary to turn from trial and error apprenticeship to formal training for hospital administrators, Alden B. Mills, administrator of the Huntington Memorial Hospital, Pasadena, and western editor of The Modern Hospital, told the regional hospital conference of the American College of Surgeons at Los Angeles April 17.

The old methods are "too slow and too haphazard" for today's needs, Mr. Mills declared. He advocated training programs to include accounting and business administration, social service, personnel, public relations, general principles of hospital architecture and plant operation, public health and hospital organization. The training program should include an internship in hospital administration, Mr. Mills added.

Standards of professional services in hospitals and trends in the institutional care of various classifications of patients were the other subjects for discussion at the conference, one of a series of regional meetings arranged by Dr. Malcolm T. MacEachern, associate director. Other conferences were held during April at Salt Lake City and at Portland, Ore.

Citizens' Committee to Back Health Bill Formed in Chicago

Formation of a citizens' committee to back the national health bill and fight the organized opposition of the medical profession was announced in Chicago April 10.

Known as the Citizens' Committee to Extend Medical Care, the group stated that its purpose would be to oppose the efforts of the American Medical Association and National Physicians Committee for the Extension of Medical Care in their efforts to defeat the health bill.

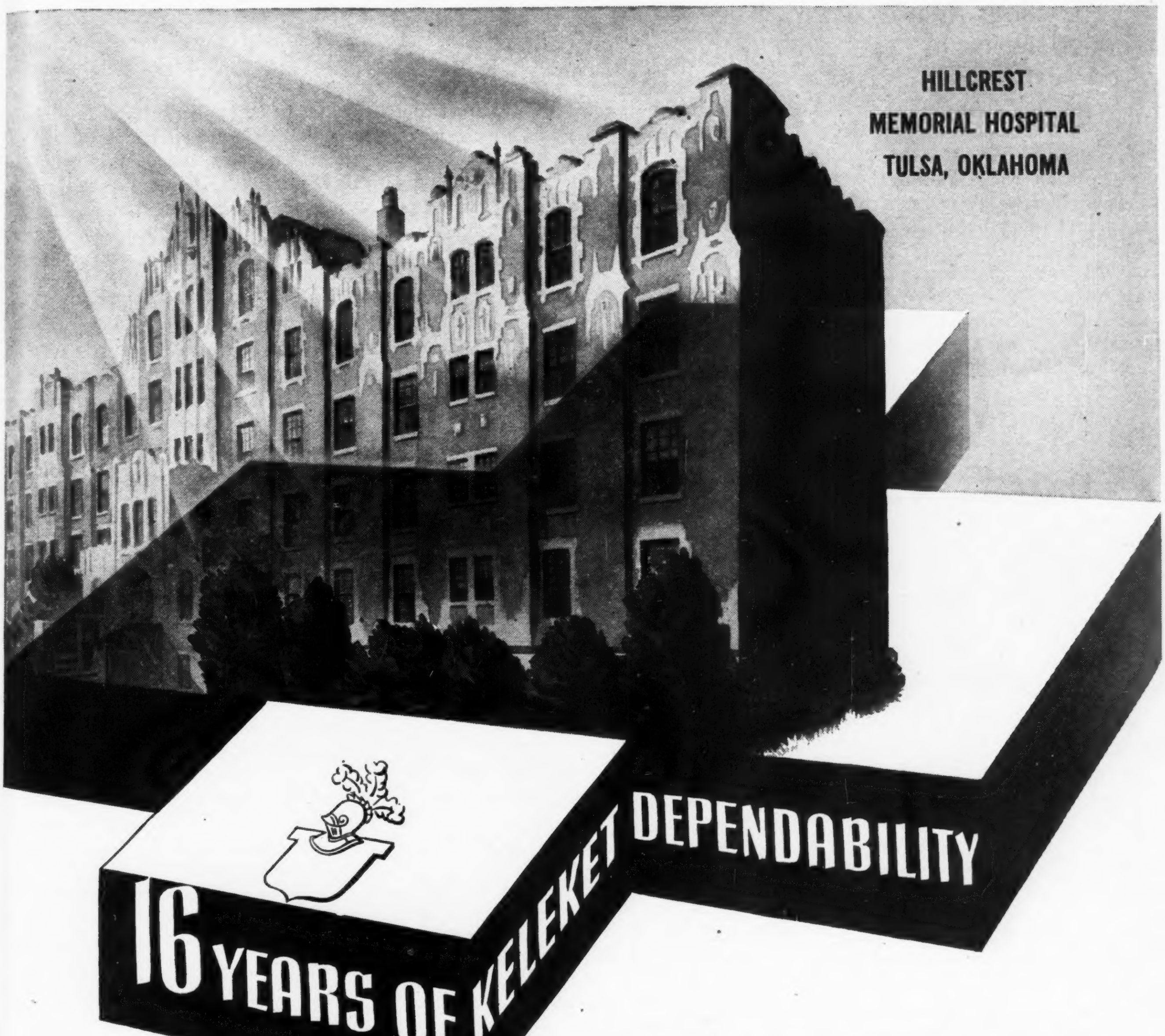
Co-chairmen of the citizens' committee are Alton A. Linford of the University of Chicago and Dr. Deborah Dauber. Mrs. Mary B. Wirth, wife of Louis Wirth, University of Chicago professor, is secretary. Affiliated organizations include the Chicago chapters of the American Association of Social Workers, Physicians Forum, Independent Voters of Illinois and Lawyers Guild.

Washington Names Officers

Nan Rowlands, R.N., administrator of Cobb Hospital, Seattle, was elected president of the Washington State Hospital Association at its annual convention in Tacoma. Other officers named are as follows: president elect, Dr. Burton A. Brown, administrator, Pierce County Hospital, Tacoma; secretary-treasurer, A. L. Holberg, business manager, Maynard Hospital, Seattle; executive secretary, Jewell Drake, R.N., Cobb Hospital; first vice president, Mrs. Cecile Tracy Spry, R.N., administrator, Everett General Hospital, Everett; second vice president, Sister Brendan, Sacred Heart Hospital, Spokane; third vice president, Horace Turner, administrator, Deaconess Hospital, Spokane.

V.A. Takes Over 4000 Beds

Washington, D. C.—With the taking over April 1 of four former Army general hospitals, the Veterans Administration gained nearly 4000 additional beds for sick and wounded veterans. These will add to V.A.'s capacity 3500 general medical and surgical beds, 400 beds for tuberculous veterans, and 500 for those needing care in veterans' homes. The new hospitals acquired are: McGuire at Richmond, Va., Vaughn, at Hines, Ill., Nichols at Louisville, Ky., and Birmingham at Van Nuys, Calif.



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Price Ceilings Removed From Many Items of Interest to Hospitals

By EVA ADAMS CROSS

Washington, D. C.—Price ceilings were suspended on April 8 by the O.P.A. from hundreds of items, many of which are of interest to hospitals. O.P.A. also discontinued price ceilings on industrial machinery and equipment. Products covered by the suspension order were described as of only minor importance in living costs or in the cost of doing business. The agency declares it will reinstate controls where prices rise unreasonably.

Among items released from price ceilings that are of particular interest to hospitals are: mops, mop sticks, knife sharpeners, clothes drying racks, hand tire pumps, ladders, gang and power lawn mowers, lawn sprinklers, thermometers, minor business machines (such as checkwriters), bottle coolers, soap dispensers, dentures, hypodermic needles and syringes.

The order suspended the ceilings from six broad classes of machinery and equipment, including many items of electrical equipment and machine tools, as well as processing, construction, transportation and miscellaneous machinery.

The Office of Price Administration clarified the recent exemption of institutional kitchen appliances and fixtures by providing that such items as slicing machines, choppers, food grinders and coffee grinders, commonly used in institutional kitchens, are not exempt.

Consumer durable goods not affected by the April 8 action are: domestic cooking and heating stoves; domestic washing and ironing machines; vacuum cleaners; household mechanical refrigerators; wool floor coverings; new coil and flat bedsprings and metal beds; feathers and down; metal upholstery springs, constructions and accessories; feather-filled pillows and upholstery cushion innercasings; china and pottery; imported Swiss watches; fountain pens and mechanical pencils; radio receivers and phonographs.

Colorado Dietitians Meet

The effects of lack of certain food elements on the world's health formed the center of much discussion at the annual meeting of the Colorado Dietetic Association held April 3 in Denver. According to Dr. Essie White Cohn, professor of chemistry, University of Denver, the new dark flour contains three times as much vitamin B_1 as the old flour. Sugar rationing, too, is no critical hardship because a "sweet tooth" often leads to a decayed tooth. Kitchens of the future, according to Roland L. Linder, Denver architect, may employ radio heating for cooking and baking. Mr. Linder also urged greater cooperation between architects and dietitians in meeting some of the problems of kitchen layout. The new president of the association is Mary Ellen Johnson, administrative dietitian, St. Luke's Hospital. Elizabeth Wolfe of the Colorado General Hospital was elected treasurer and Mary Ruth Bedford, Presbyterian Hospital, was elected secretary.

Report on O.A.B. Payments

Washington, D. C.—Benefit payments totaling $1,005,000,000 have been authorized under the old-age and survivors insurance program of the Social Security Act, Watson B. Miller, Federal Security Administrator, reports. Of this total, 48 per cent went to retired workers in monthly benefit payments; 44 per cent, in monthly benefits and lump-sum payments, to survivors of deceased workers, and 8 per cent, to dependents of retired workers.

Reappointment of Bush Asked

Washington, D. C.—H. J. Resolution 333, introduced April 1, asked that Dr. Vannevar Bush be reappointed to the board of regents of the Smithsonian Institution for a six year term.

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V.A. to Accept Collect Calls on Payment for Emergency Care

WASHINGTON, D. C.—When physicians wish to ascertain whether they will be paid by the Veterans Administration for emergency treatments to veterans, the V.A. will accept collect telephone calls to its nearest office, it is announced. Although this procedure has been approved, such authorization is not needed before the treatment can be started in an emergency, it is pointed out by the Veterans Administration.

Under existing regulations, such payments are made only for service-connected disabilities and the Veterans Administration will not be responsible for treatments given after it has been determined that the veteran is suffering from a disability that is not service-connected.

Before reimbursement is possible, V.A. regulations require that the following conditions be met: (1) it must be an emergency; (2) it must be a service-connected disability, the only exception being an emergency before a determination cited in the foregoing paragraph, and (3) no V.A. facilities are immediately available in which to treat the veteran.

600 Physicians Added to Veterans' Hospitals

WASHINGTON, D. C.—Approximately 600 physicians have been added to the Veterans Administration medical staff in 17 hospitals through the "deans' committees" which represent the nation's Class A medical schools, according to Dr. Paul R. Hawley, chief medical director. Included in the group are 224 resident physicians on full-time duty in twelve V.A. hospitals and 353 senior and junior consultants in 17 V.A. hospitals.

Thirty veterans' hospitals are now affiliated with the "deans' committees," Doctor Hawley reports, and 48 Class A medical schools have residency training available under their "deans' committees." Within the next month, at least 100 additional resident physicians are expected to be on duty in hospitals already cooperating with the Veterans Administration.

Name V.A. Section Chiefs

WASHINGTON, D. C.—Five additional physicians have been named as part-time chiefs of sections in the Professional Service Division of the Veterans Administration, according to an announcement by Dr. Paul R. Hawley, chief medical director. The new specialists and their fields follow:

Dr. James S. Simmons, Boston, tropical medicine; Dr. Albert M. Snell, Mayo Clinic, Rochester, Minn., gastro-enterology; Dr. Charles C. Wolferth, University of Pennsylvania Hospital, Philadelphia, cardiology; Dr. Harry L. Alexander, Barnes Hospital, St. Louis, allergy, and Dr. James H. Maxwell, University of Michigan Medical School, Ann Arbor, otolaryngology.

Food Conservation Ordered

WASHINGTON, D. C. — Cooperating with the Famine Emergency Committee's food conservation campaign, the Veterans Administration on April 8 ordered its hospital managers to "ensure that food is not wasted." The V.A.'s 101 hospital managers were particularly instructed about using flour made from soy beans.

Although all necessary steps were to be taken toward conservation of food, the directive pointed out, however, that patient menus must not be penalized by a reduction of standards.

Plan Carolinas-Va. Meeting

Presentation of nationally recognized authorities in the hospital field and showing of new postwar equipment and supplies will feature the two day Carolinas-Virginia Hospital Conference opening Wednesday, May 22, at Greenville, S. C. The afternoon session on May 23 will be devoted to problems of trustees.

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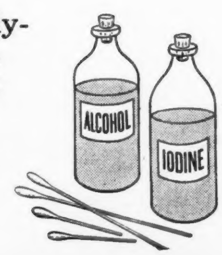

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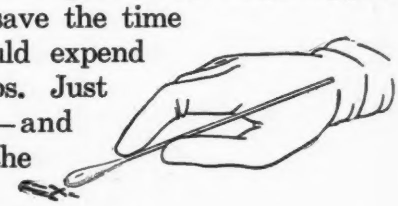

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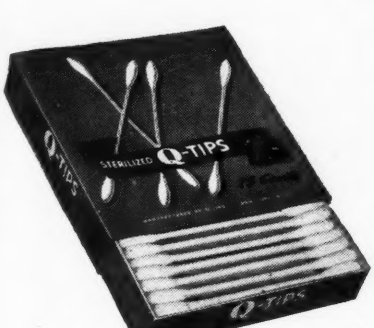

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Greater N. Y. Hospitals Study City Planning

A progress report on the activities of the Hospital Council of Greater New York was presented before a recent meeting of the Greater New York Hospital Association by Edwin A. Salmon, chairman. As a fundamental part of its program the council has in preparation an over-all plan for medical service and related facilities in the city.

Before summer it is hoped that the council will be able to make available for study a preliminary over-all plan for the distribution and allocation of hospitals in New York. In this connection the council has given serious consideration to the existing hospitals' fiscal plans, their needs and relationship to the communities they serve and also their relationship to other hospitals. Appearing with Mr. Salmon in presenting the work of the council was Dr. John B. Pastore, executive director of the council, who discussed the special work now in progress.

The annual luncheon of the association will be held June 10 during the convention of the New York Hospital Association at the Hotel Pennsylvania in New York City.

Announce Program of N.E.H.A. Biennial Session

Things to come in color, furnishings and human relations will be the main topics discussed at the biennial congress of the National Executive Housekeepers' Association to be held in Atlantic City, N. J., May 21 to 23. The session will open Tuesday evening with an informal reception at the Seaside Hotel.

Official proceedings will start Wednesday morning when, following registration and the reports of the program and credentials committees, N. A. Mason, Pittsburgh Plate Glass Company, Pittsburgh, will lecture on "Color Dynamics and Building Maintenance Through the Use of Paints."

During the afternoon meeting on Wednesday, Walter P. Margulies, French furniture designer, will describe new furniture, finishes, fabrics and wall coverings. It is expected that the speaker will bring with him slides and samples showing the new designs.

Thursday morning will be devoted to a discussion of "Human Relations" by Meredith C. Wiley.

On Thursday afternoon new officers and board members will be elected and inducted into office. The congress will close with a reception and banquet at the Hotel Madison.

Books of tickets covering registration and all luncheons, dinner and banquet will be available to N.E.H.A. members at a cost of $15.


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Gallinger Asks Funds to Permit Hiring of 20 Additional Nurses

WASHINGTON, D. C.—That the deaths of 267 premature babies at Gallinger Hospital, Washington, D. C., in the last six years could have been prevented by an adequate nursing staff was brought out in hearings ending April 18 before a Senate appropriations subcommittee. The hearings were held to consider a request for more funds to hire nurses at Gallinger. The figures were submitted by Dr. Lewis Sweet, chief medical officer for the pediatrics division.

Senator O'Mahoney, chairman of the committee, has asked a separate Senate deficiency appropriations subcommittee for $7000 of emergency funds to permit the hiring of about 20 nurses in the next two months. The director of nurses of the hospital had testified that nurses seeking jobs had been turned away because no money would be available to pay them until after June 30.

District and Gallinger officials were ordered to study the hospital's budget, make sure it fits present needs, and then report the revised money estimates to the subcommittee. The hospital's medical administrative committee has been asked for recommendations as to how the institution's defects can be corrected and how it can be placed on a high professional and medical standard.

Early in March the District commissioners made the Capital City School of Nursing an autonomous department at Gallinger Hospital in a move to enable its permanent accreditation, it has been announced. The District Nurses' Examining Board and the National League of Nursing Education had objected to the fact that Gallinger Hospital had used the school primarily as a reservoir for nurses rather than primarily as an educational institution. The school is now provisionally accredited.

Alvin R. Sweeney, hospital superintendent, has already started a program of reemphasis on education by cutting the work week of the nurses enrolled in the school to forty-eight hours. The hours will shortly be cut to forty.

Grant Funds for Quebec Hospital

A grant of $400,000 for the construction of a new 150 bed hospital in Sherbrooke's North Ward, Sherbrooke, Que., to replace the Sherbrooke Hospital now considered inadequate for present requirements, has been made by the provincial government, it has been announced. The subsidy came as the result of a proposal for the construction of a new $1,000,000 hospital to meet present and future demands. Sale of the present hospital will bring $250,000, and the balance of $350,000 will be raised by private subscription.

Truman Lauds P.H. Nurses

In conjunction with the first annual observance of Know Your Public Health Nurse Week, April 7-13, President Truman paid tribute to the nation's more than 20,000 public health nurses in a message released by Federal Security Administrator Watson B. Miller. The observance, Mr. Truman asserted, brings "long overdue public recognition to one of the most important groups of health workers in the country. I am pleased that this annual tribute has been inaugurated at a time when our people are awakening to the necessity for a greatly expanded public health program."

Huntington Hospital to Expand

Plans are underway to make the Huntington Hospital, Huntington, N.Y., the medical center of Suffolk County. Expansion plans include the establishment of a nursing school with a nurses' home and out-patient department. After comprehensive surveys were made, it was recommended that the hospital's over-all facilities be doubled.

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Congratulate R. I. Plan on Enrollment Success

A resolution of congratulations to the Rhode Island Blue Cross on achieving enrollment of 50 per cent of the eligible population of the state was passed at the close of a three day general meeting of the New England Hospital Assembly at the Statler Hotel, Boston.

The enrollment of Governor John O. Pastore as subscriber number 350,000 on February 20 brought the membership of the R. I. Blue Cross to the half-way mark, together with the distinction of being the first state in the Union to enroll 50 per cent of its eligible population.

Members of the resolutions committee included Dr. Wilson W. Knowlton of Boston Lying-In Hospital; Mabel L. Parsons of Elliot Community Hospital, Keene, N. H., and Robert N. Brough of Norwalk General Hospital, Norwalk, Conn.

Hospital Veterans Organize

A new veterans' organization to obtain jobs for members in hospitals, laboratories, drug companies and other medical fields has been organized with headquarters at 1705 M Street, N. W., Washington, D. C. Buford E. Kirwan, retired naval lieutenant and a veteran of both wars, is president of the organization which will be known as the National Association of Veterans of the Hosptial Corps. Raymond Watson is the organizer.

Patients Die in Fire

Fifteen male patients burned to death in a fire which destroyed the infirmary ward of Kingston Mental Hospital, Kingston, Jamaica, where a labor crisis brought about a strike in which three persons were killed in street fighting between rival labor unions.

With nurses and attendants on strike, the two thousand patients were left unsupervised, scores wandering about the streets in search of food. The fire, which occurred during the night, was one of several believed set by the patients.

1300 Counties Lack Hospitals

There are 1300 counties in the nation without any general hospitals, W. R. Ogg, representing the American Farm Bureau Federation, stated in an appearance before a House interstate commerce subcommittee in behalf of legislation which already has been passed by the Senate. The legislation would authorize appropriation of $375,000,000 during the next five years to assist the states in construction of hospitals and health centers.

Hospitals Receive Bequests

Children's Memorial Hospital, Chicago, and Saginaw General Hospital, Saginaw, Mich., will share in the $250,000 estate of the late Mrs. Alma M. Dewes, widow of August Dewes, a brewer. The will includes a bequest of $25,000 to Children's Memorial and $50,000 to Saginaw General.

Auxiliaries Join Association

Hospital auxiliaries throughout the state of Minnesota have agreed to form a statewide organization and will become an official group within the Minnesota Hospital Association, it has been announced. The auxiliaries will hold their organization meetings at the time of the annual convention of the state association in St. Paul May 26 to 28.

Doctor Pottenger Honored

Dr. Francis M. Pottenger, one of the nation's pioneer tuberculosis workers and one of the founders of the first anti-tuberculosis society in California was named to the newly created office of president emeritus of the Los Angeles County Tuberculosis and Health Association at the annual meeting of the organization.

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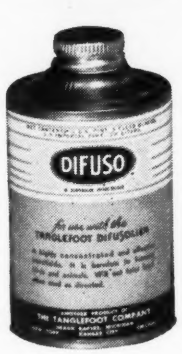

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OTHER TANGLEFOOT PRODUCTS • *TANGLEFOOT GUMMED KRAFT SEALING TAPE, TREE TANGLEFOOT, AND TANGLEFOOT FLY PAPER*

Grant Scholarship Funds for T.B. Nursing

A grant of $10,000 for a scholarship fund for the preparation of nurses for teaching and supervisory positions in tuberculosis nursing has been made by the National Tuberculosis Association to the National Organization for Public Health Nursing, according to Dr. Kendall Emerson.

Applications for scholarships are to be sent to Mrs. Louise Lincoln Cady, tuberculosis consultant, National Organization for Public Health Nursing, 1790 Broadway, New York 19. They will be reviewed by a tuberculosis nursing scholarship committee of which Alta E. Dines, director, division of education nursing, Community Service Society of New York, is chairman. Requests will be accepted until May 31 from any nurse interested in tuberculosis but preference in making the awards will be given to nurses with experience in tuberculosis nursing and supervision.

Graduate Training for A.M.C.

WASHINGTON, D.C. — A new Army regulation authorizes the establishment of an organized program of graduate education for "the elevation of the general level of professional qualifications of all Medical Corps officers," according to the Surgeon General's office.

Among other things, with the approval of the surgeon general, specialty training may be supplemented by service school instruction or a civilian teaching institution. Postgraduate training in medical and surgical subspecialties and preventive medicine will be offered at service schools, installations or at civilian teaching institutions.

COMING MEETINGS

ALBERTA HOSPITAL ASSOCIATION, Palliser Hotel, Calgary, Nov. 6-8.
AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Philadelphia, Sept. 30-Oct. 4.
AMERICAN ASSOCIATION OF MEDICAL SOCIAL WORKERS, Buffalo, N. Y., May 20.
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Bellevue-Stratford Hotel, Philadelphia, Sept. 30-Oct. 3.
AMERICAN ASSOCIATION OF SOCIAL WORKERS, annual delegate conference, Hotel Statler, Buffalo, N. Y., May 17-19.
AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Philadelphia, Sept. 28-30.
AMERICAN COLLEGE OF PHYSICIANS, Philadelphia, May 13-17.
AMERICAN CONGRESS OF PHYSICAL MEDICINE, Hotel Pennsylvania, New York, Sept. 4-7.
AMERICAN DIETETIC ASSOCIATION, Netherland Plaza Hotel, Cincinnati, Oct. 14-18.
AMERICAN HOSPITAL ASSOCIATION, Hotels Bellevue-Stratford and Be jamin Franklin, Philadelphia, Sept. 30-Oct. 3.
AMERICAN NURSES' ASSOCIATION, Atlantic City, N. J., Sept. 23-27.
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC., Congress Hotel, Chicago, Aug. 11-15.
AMERICAN PHARMACEUTICAL ASSOCIATION, Hotel William Penn, Pittsburgh, Aug. 25-30.
AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Bellevue-Stratford Hotel, Philadelphia, Sept. 27-28.
AMERICAN PSYCHIATRIC ASSOCIATION, Palmer House, Chicago, May 27-30.
AMERICAN SOCIETY OF HOSPITAL PHARMACISTS, Hotel William Penn, Pittsburgh, Aug. 25-30.
ARKANSAS HOSPITAL ASSOCIATION, Hotel Lafayette, Little Rock, May 16-17.
ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, May 14-16.
CANADIAN NURSES' ASSOCIATION, Royal York Hotel, Toronto, July 1-4.
CAROLINAS-VIRGINIAS HOSPITAL ASSOCIATION, Hotel Poinsett, Greenville, S. C., May 22-23.
CATHOLIC HOSPITAL ASSOCIATION, Hotel, Schroeder Milwaukee, June 10-13.
HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Pennsylvania, New York City, June 10-12.
MAINE HOSPITAL ASSOCIATION, Belgrade Hotel, Belgrade, June 21-22.
MARITIME HOSPITAL ASSOCIATION, Pines Hotel, Digby, N. S., June 25-27.
MARYLAND-DISTRICT OF COLUMBIA HOSPITAL ASSOCIATION, Washington, D. C., Nov. 7-8.
MISSISSIPPI STATE HOSPITAL ASSOCIATION, Edgewater Gulf Hotel, Edgewater Park, Oct. 17-19.
NATIONAL CONFERENCE OF SOCIAL WORKERS, Buffalo, N. Y., May 19-25.
NATIONAL COUNCIL OF CATHOLIC NURSES, Hotel Commodore Perry, Toledo, Ohio, May 24-26.
NATIONAL EXECUTIVE HOUSEKEEPERS' ASSOCIATION, Atlantic City, May 21-23.
NATIONAL MEDICAL ASSOCIATION, Louisville, Ky., Aug. 19-23.
NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC., Atlantic City, N. J., Sept. 23-27.
NEBRASKA HOSPITAL ASSEMBLY, Sectional Meetings: Lincoln, Holdredge, Lexington, Alliance, Norfolk, May. Annual Conference: Oct. 21-22.
NORTH DAKOTA HOSPITAL ASSOCIATION, Hotel Ryan, Grand Forks, May 9-10.
OKLAHOMA STATE HOSPITAL ASSOCIATION, Oklahoma City, Nov. 21-22.
ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 21-23.
OREGON ASSOCIATION OF HOSPITALS, Osburn Hotel, Eugene, May 23-24.
UTAH STATE HOSPITAL ASSOCIATION, Salt Lake City, June 6.

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Navy Nurses Given Time to Decide on Transfer; Point Score Reduced

WASHINGTON, D.C. — Naval Reserve nurses are now permitted to leave the service and take six months to decide whether or not they wish to rejoin the Navy, transferring to the Regular Nurse Corps, according to an announcement in March. They are thus accorded the same privilege in this matter of time which has been extended by the Navy to the men of the Naval Reserve.

The total point score necessary for release of Naval Reserve nurses to inactive duty was cut to 25 on April 1. It was then cut to 23 on May 1 and will be reduced to 21 on June 1. These reductions will release approximately 2800 more nurses to civilian life by July 1 than would have been the case if the score had been kept at the March total of 27 points.

Hospital Bureau Elects Directors

The following were elected to the board of directors at the thirty-sixth annual meeting of the Hospital Bureau of Standards and Supplies, Inc., at the Hotel McAlpin, New York City:

Fred Heffinger, superintendent, Manhattan Eye, Ear and Throat Hospital, New York City; George F. Holmes, superintendent, Memorial Hospital, New York City; F. Stanley Howe, director, Orange Memorial Hospital, Orange, N. J.; Neal R. Johnson, purchasing agent, Johns Hopkins Hospital, Baltimore; John F. McCormack, superintendent, Presbyterian Hospital, New York City; William E. P. Collins, superintendent, Staten Island Hospital, Tompkinsville, N. Y.

Officers of the board were named as follows:

President, John F. McCormack; vice president, Willard W. Butts, superintendent of St. Luke's Hospital, Bethlehem, Pa., and secretary-treasurer, F. Wilson Keller, superintendent of the Hospital for Special Surgery, New York City.

Western Hospitals to Meet

"The Hospital of Tomorrow" has been announced as the theme of the first postwar convention of the Association of Western Hospitals at Los Angeles May 14 to 16. Knowledge gained from the war in the fields of management, personnel, construction and many other problems of hospital administration will be presented in relation to current and future bearing on hospitals and equipment. Dr. C. G. Salsbury, president of the Association of Western Hospitals, will preside.

Scientists to Receive Awards

WASHINGTON, D.C. — Medals of merit are shortly to be presented to three eminent scientists in recognition of their part in the Army's preventive medicine program, it was learned at the Office of the Surgeon General March 18. Dr. Francis Gilman Blake, president of the Army Epidemiological Board; Dr. Alfred Newton Richards, chairman of the committee on medical research, Office of Scientific Research and Development, and Dr. Lewis H. Weed, chairman of the Division of Medical Sciences, National Research Council will receive the awards signed by President Truman.

More Negro V.A. Hospitals

WASHINGTON, D. C.—Additional hospitals for Negro veterans will be built by the Veterans Administration and staffed by Negro physicians and other personnel, V.A. officials here have indicated. It is expected that an additional unit will be added to the present Negro V.A. hospital at Tuskegee, Ala., and that another such unit will be built at Macomb, Miss. The V.A. is also considering the advisability of staffing Negro sections of many large veterans' hospitals with Negro personnel.

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Eye and Ear Infirmary Affiliates With N.Y.U.-Bellevue Medical Center

The New York Eye and Ear Infirmary, oldest hospital of its kind in North America and the third oldest hospital of any kind in New York City, will become affiliated with the proposed New York University-Bellevue Medical Center project, according to Robert M. Youngs, president of the board of directors of the infirmary. A campaign is already under way to raise $15,000,000 which is New York University's share of the project; the city is expected to spend $22,000,000 in rebuilding its present Bellevue Hospital area.

Founded in 1820, the infirmary is now housed in a 50 year old brownstone building at Second Avenue and Thirteenth Street. The institution will retain its identity but will occupy a section of the new University Hospital when construction of the project is completed.

The affiliation, which brings the specialized infirmary into a close physical relationship with a general hospital, follows a trend developed during the last twenty-five years, Mr. Youngs explained.

Paraplegic Section at Vaughan General Nearing Completion

The major portion of the paraplegic section at Vaughan General Hospital, Hines, Ill., has been completed, and a daily program has been established whereby 85 per cent of the patients are expected to attain a physical condition that will permit them to return home, according to Capt. Leslie W. Freeman, M.C., formerly of Mayo General Hospital, Galesburg, Ill., and recently assigned as chief of the paraplegic section at Vaughan. When completed, the section will be capable of caring for more than 300 paraplegics.

The first group of 37 patients from Nichols General Hospital, Louisville, Ky., and another group of 117 from Percy Jones General Hospital, Battle Creek, Mich., have been admitted, Brig. Gen. P. J. Carroll, M.C., has announced

The service of one and one half persons per patient is necessary to provide the best possible care, Captain Freeman stated. "This includes nurses, ward men, surgical technicians, cleaners and sundry assistants, as well as medical and surgical officers."

As the program, which consists primarily of special diets, regular exercise, physical therapy treatments, baths, occupational therapy and specially adapted recreation activities, is developed, it is expected that facilities will be broadened to include education, job training, job planning, outlining of business ventures and other opportunities aimed at providing the maximum independence for the individual. To accomplish this, a system of self-care is taught.

Other Army paraplegic centers are located at McGuire General Hospital, Richmond, Va.; Cushing General Hospital, Framingham, Mass.; Birmingham General Hospital, Van Nuys, Calif., and Kennedy General Hospital, Memphis, Tenn.

Recruit Doctors for V.A. Rating Boards

Washington, D. C.—An intensive recruitment campaign for physicians to fill more than 400 vacancies on rating boards in regional offices of the Veterans Administration was announced March 29. These boards pass on claims for disability made by veterans. The posts now carry a starting salary of $5180 a year. Applications should be made at the regional office in which the physician desires to serve.

Medical rating specialists may serve on a part-time basis of less than four hours a day. Consideration will be given to employment of physicians who cannot meet minimum physical standards but are otherwise qualified.

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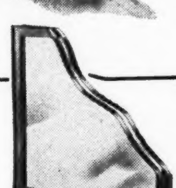

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Repair Service of Prosthetic Devices Aids Amputee Veterans

"Prosthetic service cards," which entitle the bearer to prompt repair of his artificial limbs at government expense, will be distributed to amputee veterans beginning within the next sixty to ninety days, the Veterans Administration has announced. Walter Bura, acting director of V.A.'s Prosthetic Appliance Service, expects distribution to start about May 15.

The card, according to Mr. Bura, will enable a veteran to go direct to any repair establishment in the country, show his card and obtain the necessary repairs up to a maximum of $35. The invoice will include the veteran's signature, "C" or V.A. file number, itemized statement of repairs and time involved and will be sent to the V.A. regional office listed on the card for payment. To protect the government from excessive charges, an adequate policing measure will be inaugurated.

$1,000,000 Hospital Planned

A 250 bed hospital, costing $1,000,000 and to be known as Libuse Park Hospital, has been approved by the board of trustees of Stickney, Chicago district. Construction of the hospital at 4300 South Harlem Avenue, Chicago, is expected to begin by autumn, according to Dr. Helding Cleminson, superintendent of S[illegible]town Hospital, leader of a group which is promoting Libuse Park Hospital.

Nurse adjusts a new type of breathing aid apparatus on a patient. The "plastic lung" which the patient can carry with him weighs 60 pounds with all attachments. It is used in cases of asphyxiation.

A.C.S. Will Resume Clinical Congress at New York Meeting

Plans have been announced for the thirty-second Clinical Congress of the American College of Surgeons, September 9 to 13 at the Waldorf-Astoria, New York City.

Highlighting the congress, which will be the first since the meeting in Boston in 1941, will be the installation of the officers-elect headed by Dr. Irvin Abell, chairman of the board of regents, as president. Officers, regents and governors have remained in office since 1941 because of the cancellation of annual meetings of the fellows, and Dr. W. Edward Gallie of Toronto has served as president since November 1941. He will give the presidential address at the presidential meeting and convocation on the evening of September 9 in the Grand Ballroom of the Waldorf-Astoria.

During the last four years, 2744 surgeons have been received into fellowship *in absentia,* and a large number is expected to be present for the formal initiation ceremonies. Attendance at the congress is usually around 5000 surgeons and hospital representatives.

The extensive program of demonstrations, scientific sessions, panel discussions, symposiums, forums, hospital standardization conference, medical motion pictures, business meetings and educational and technical exhibits will be held in the headquarters hotel, and operative and nonoperative clinics will be held in the local hospitals.

Dr. Howard A. Patterson and Dr. Frank Glenn of New York City are chairman and secretary, respectively, of the committee on local arrangements, and Dr. Henry Cave of New York is active also in directing the local plans.

Medical Plan Broadens Service

Liberalization of enrollment regulations for persons desiring surgical and medical care in hospitals and provision to pay for minor surgical operations performed in a doctor's office have been announced by United Medical Service, Inc., 370 Lexington Avenue, New York City, through its president, Rowland H. George. Under regulations similar to those in New York's Blue Cross plan, Associated Hospital Service of New York, small employed groups and individuals not affiliated with groups may now subscribe to U.M.S. which is sponsored by the Medical Society of New York and 17 county medical societies. Approximately 10,000 physicians cooperate in the service and more than 175,000 persons in Greater New York now subscribe to the three plans offered by U.M.S.

Navy Nurses Honored for Heroic Service

WASHINGTON, D. C.—Lt. Cmdr. Laura May Cobb, N. C., U. S. Navy, received the Avon Award for Achievement—a medallion of honor and a $1000 Victory Bond, according to an announcement of Cmdr. Nellie Jane Dewitt, superintendent, Navy Nurse Corps.

The award was presented to Commander Cobb at a luncheon forum sponsored by the Soroptimist Club and held at the St. Francis Hotel in San Francisco. It was made for the heroic work of this Navy nurse among sick and wounded internees in prison camps in the Philippines over three years of imprisonment by the Japanese.

In addition to the principal award to Miss Cobb, smaller Avon awards of $200 Victory Bonds were presented at the same time to the 10 nurses who worked with Miss Cobb during the months of imprisonment. They were: Lieutenants Mary Chapman Hays, Chicago; Bertha Rae Evans, Portland, Ore.; Helen C. Gorzelanski, Omaha, Neb.; Mary Harrington Nelson, Elk Points, S. D.; Margaret A. Nash, Wilkes-Barre, Pa.; Goldia O'Haver Merrill, Ottumwa, Iowa; Eldene E. Paige, Lomita, Calif.; Susie J. Pitcher, Chicago; Dorothy Still, Long Beach, Calif., and C. Edwina Tood, Pomona, Calif.

The committee which selected Miss Cobb for the highest award was comprised of Fannie Hurst, novelist; Gladys Swarthout, opera star, and C. Mildred Thompson, dean of Vassar College.

Miss Cobb, a native of Wichita, Kan., is now chief nurse at the naval hospital, Treasure Island, Calif. She wears the ribbons of the Bronze Star Medal, a Gold Star in lieu of a second Bronze Star Medal, and the Distinguished Unit Badge presented by the Army, in addition to several campaign ribbons and two battle stars.

OFFICIAL ORDERS

Building Materials.—Maximum prices on cast-iron plumbing drainage staples have been raised an average of 11 per cent as of March 28; sand lime building brick prices were raised $2 per thousand bricks on April 6.

On April 16, resinous coated steel sheets and cork composition products, with the exception of die-cut gaskets and shape specialties, were placed under price control methods applicable to most building materials. This, however, has no effect on current prices of these materials.

Mattresses.—Controls over mattress prices have been strengthened by the O.P.A. recently. Most branded items may be increased up to $1.50 but as a result of the action consumers' prices on many mattresses will be reduced. The purpose of the action is to encourage the production of branded wire tied innerspring mattresses.

An increase of from 15 cents to $1.25 each is now in effect on the price of soft mattresses—blown, plated, and felt cotton types. These were in substantial production during the war and so are not classified as a reconversion product. The increase is the first allowed since 1942.

Price Controls.—Maximum prices have now been provided on sales of aerosol insecticide dispensers in smaller than one pound sizes at all levels of distribution, the O.P.A. announced on April 3.

An increase of between 8 and 10 per cent at the consumer level may be expected on cameras, projectors and most photographic accessories, according to an O.P.A. ruling of April 11. In addition, consumers will pay the dollar amount of the excise tax levied on the manufacturer. Films and sensitized paper are excluded since the existing ceilings on these items are now satisfactory.

Rubber Footwear.—The government is now offering for sale, under dollar-and-cent ceiling prices, quantities of the men's and women's rubber footwear which has been declared surplus by the armed forces and war agencies. The prices are identical with those for similar items being sold in regular civilian channels. Some of the items are available for sale through the regional offices of the War Assets Administration.

Textiles.—On April 15 the O.P.A. announced a new wholesale pricing method for bedspreads and tablecloth fabric, tablecloths and napkins. The action became effective April 20 and under it any part of the producers' increase that is over 20 per cent of the producers' original price may now be passed on to the consumer. Wholesalers who sell to institutional users, however, are permitted to pass on the full amount of the increases since it is felt that the cost of items covered represents only a minor expense for institutional users.

Transformers.—On April 11 the O.P.A. announced that increase factors of 11 and 19 per cent would replace the 6.3 and 14.4 per cent respectively authorized in January 1946 for fluorescent and other specialty transformers. These are the devices used in internal combustion engine ignition, lights in gas and fuel oil ignition units and electrical machinery controls.

Lower Paint Maintenance Cost

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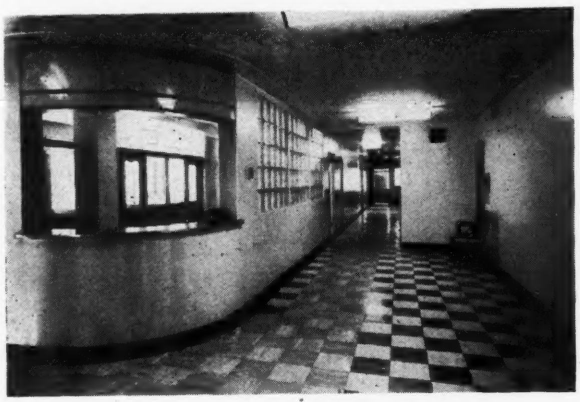
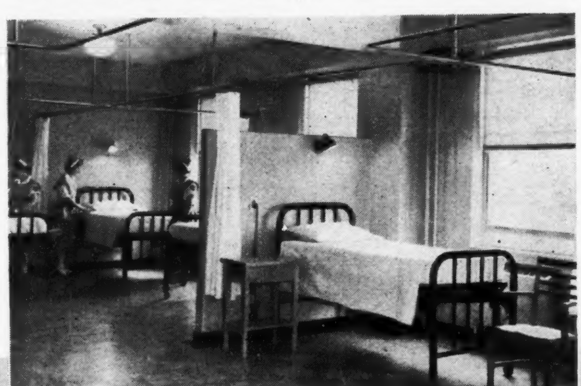




HOSPITAL authorities have found real economy in the use of Pratt & Lambert Paint and Varnish, not only in first application, but more particularly in lowered maintenance cost. Because of their proven durability, washing restores the original appearance of these P&L coatings. Frequent repainting of walls, woodwork and floors, and consequent upsetting of hospital routine, are avoided when P&L materials are used.

The distinctive, authoritative colors, in which these products are available, create a wholesome atmosphere wherever used. Broadlawns Hospital, Des Moines, Iowa, is but one example of many institutions from coast to coast where these unusual colors help to promote restoration to health.

On request, a Pratt & Lambert representative, trained in the correct use of color, will aid hospital authorities in developing complete color plans and sound painting specifications for new work and maintenance. Pratt & Lambert-Inc., 126 Tonawanda St., Buffalo 7, N. Y.

PRATT & LAMBERT PAINT AND VARNISH

ABOUT PEOPLE

(*Continued From Page* 90.)

named controller of Monmouth Memorial Hospital, Long Branch, N. J. Before entering the Navy, Mr. Ernst was employed at the University of Michigan Hospital, Ann Arbor. He received the degree of master of business administration from the University of Michigan.

Mrs. Minnie Lindsay has been appointed executive housekeeper at Rochester General Hospital, Rochester, N. Y. Mrs. Lindsay was formerly executive housekeeper at Mount Morris Tuberculosis Sanatorium, Mount Morris, N. Y.

Sister M. Hugolina Peoples, O.S.F., R.N., director of the school of nursing at St. Elizabeth's Hospital, Lincoln, Neb., has been appointed assistant director of Creighton Memorial, St. Joseph's School of Nursing, Omaha, Neb. She succeeds **Kathleen R. Bottani,** R.N., B.S.N.E., who plans to rest until fall and then resume studies in nursing. **Sister M. Ann Frances Hoff,** O.S.F., R.N., has succeeded **Sister Hugolina** at Lincoln.

Miscellaneous

Mrs. Dorothy W. Conrad has been designated acting administrator of the American Red Cross Nursing Services, succeeding **Virginia M. Dunbar** who resigned to become dean of Cornell University-New York Hospital School of Nursing, and director of the nursing service of the New York Hospital. Mrs. Conrad has served as deputy administrator since August 1944.

C. J. Foley has been appointed director of public education for the American Hospital Association, succeeding Jon Jonkel, who resigned last January. Following his discharge from the Navy several months ago, Mr. Foley has been a member of the public relations staff at Vaughan General Hospital, Hines, Ill. He served three years in the Navy as commanding officer of a minesweeper in the Caribbean and, later, in the Pacific theater, holding the rank of lieutenant.

Before the war, Mr. Foley was public relations director of the Blue Cross plan and hospital association in Wisconsin. He had been associate editor of *Hospital Management* and director of public relations for Missouri Hospital Service, St. Louis. He is a son of Matthew Foley, founder of National Hospital Day.

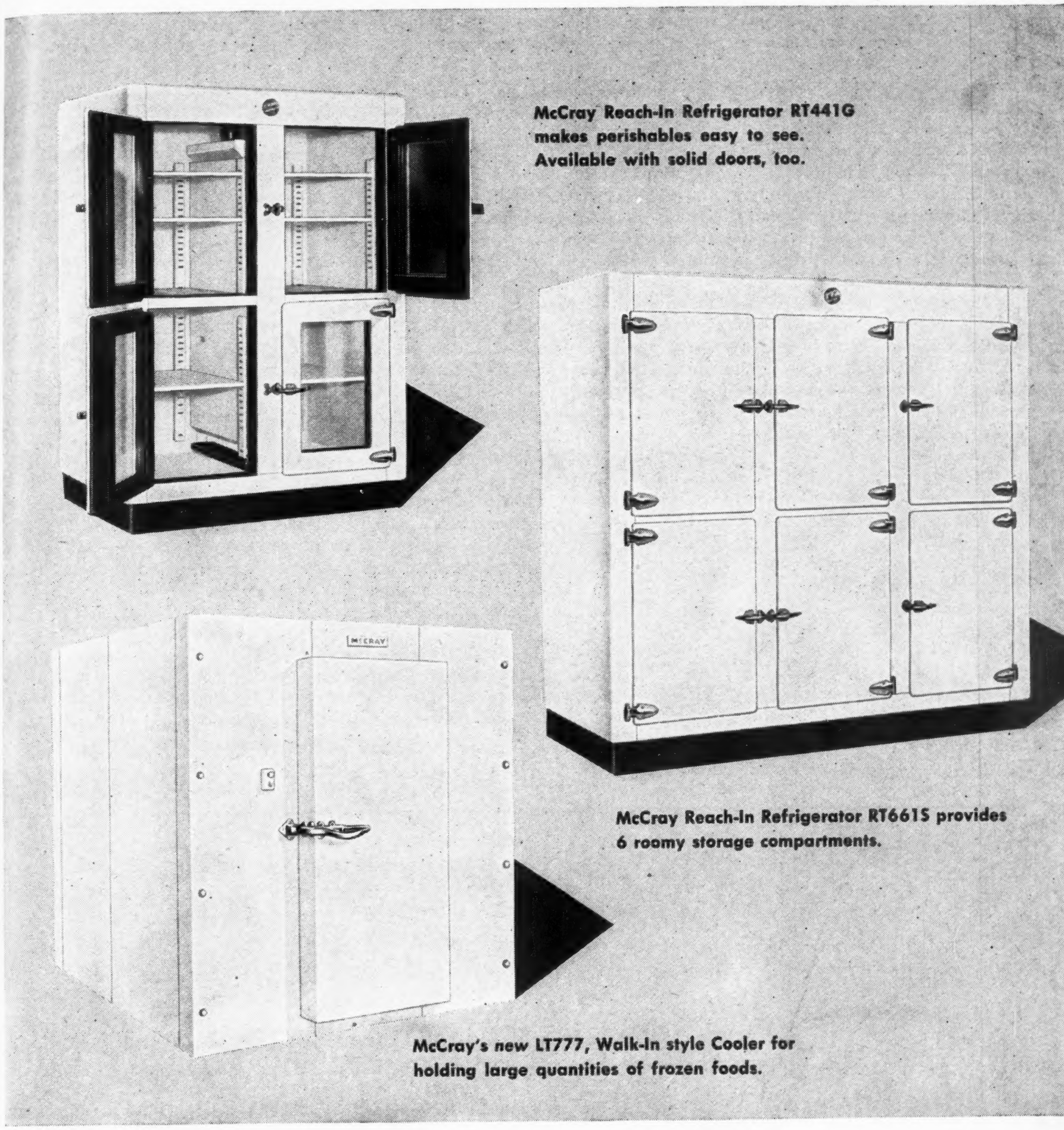
Harry Brown, director of the medical administration service, Veterans Administration, Washington, has been promoted to a full colonelcy in the U. S. Army, the Veterans Administration announced last month. Prior to his service with the Army, Colonel Brown was for ten years administrator of Northwestern Hospital in Minneapolis.

Dr. Courtney M. Smith is the new medical director for the American Red Cross, national headquarters announced April 22. Doctor Smith has served with the organization since 1944 as deputy medical director and director of disaster medical service. He succeeds **Dr. G. Foard McGinnes,** recently appointed vice chairman for Health Services.

Ruth Barnhart, formerly assistant editor of *Dental Hygiene,* has been appointed executive secretary of the Texas Hospital Association.

Dr. Albert D. Kaiser, health officer of Rochester, N. Y., has been selected as executive director of the Council of Rochester Regional Hospitals, recently established in a five year agreement with the Commonwealth Fund. **Dr. Paul A. Lembcke,** formerly state district health officer at Rochester, has been named medical associate and **Charles M. Royle,** business manager. Doctor Kaiser will continue his position as health officer but will direct the experimental regional hospital and medical project, and Mr. Royle will continue in his post as executive manager of the Rochester Hospital Council.

Dr. Thomas B. McKneely of New Orleans, a senior surgeon in U.S.P.H.S.,



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has been named assistant chief medical officer of the Office of Vocational Rehabilitation, Federal Security Agency. Other recent appointments to the O.V.R. are: **Dr. Charles L. Newberry** of Milwaukee, a surgeon in U.S.P.H.S., recently with UNRRA in Egypt and Austria, assistant medical officer; **Dr. Henry H. Kessler** of Newark, N. J., outstanding authority on amputation and kineplasty, consultant in orthopedics and prosthetic devices; **Dr. Hewitt Varney,** a surgeon in U.S.P.H.S., currently assigned to the U.S. Maritime Training Station at Sheepshead Bay, N. Y., consultant in psychiatry; **Dr. Ward L. Mould,** a surgeon in U.S.P.H.S., assistant regional representative of Region VI, embracing Missouri, Arkansas, Louisiana, Texas, Oklahoma, New Mexico and Kansas, with headquarters in Kansas City.

Nellie Jane Dewitt, U.S.N., a member of the Navy Nurse Corps for twenty-five years, has been promoted to the rank of captain as superintendent of the Navy Nurse Corps, according to an announcement of the Bureau of Medicine and Surgery, Navy Department. She became superintendent in November 1945, upon the retirement of **Capt. Sue S. Dauser.**

Col. Anthony J. Lanza, associate medical director of the Metropolitan Life Insurance Company, has received the William S. Knudsen Award for the most significant contribution to the field of industrial medicine in the current year. The award was presented at the thirty-first annual banquet of the American Association of Industrial Physicians and Surgeons at the Hotel Sherman, Chicago, in April.

Cmdr. Ruth E. Anthony, supervisor of nurses at Great Lakes Naval Training Center since August, has retired after twenty-eight years' service as a navy nurse.

Maury Maverick, former member of the House of Representatives from Texas and known to hospital people for his work with the War Production Board during the early years of the war, has opened a law office in Los Angeles. At the time of his service with W.P.B., Mr. Maverick appeared on the programs of numerous hospital meetings to explain priority regulations affecting hospitals.

Cmdr. Elizabeth O'Brien, one of the Navy Nurse Corps leaders for many years, was recently awarded a commendation with ribbon by the Secretary of the Navy for outstanding service to the Nurse Corps. Commander O'Brien, at present on duty as senior nurse in the Twelfth Naval District, with headquarters in San Francisco, served as senior administrative assistant to the superintendent of the Nurse Corps through the war years.

Harley B. West, recently discharged from the Army with the rank of colonel, is joining the Texas Blue Cross Plan as associate director in charge of enrollment, according to **Walter McBee,** executive director.

Marile L. Brophy, Hines, Ill., has been named chief of Veterans Administration nursing services in Illinois, Indiana and Wisconsin.

Col. Edward T. Thompson, formerly administrator of Mount Sinai Hospital, Milwaukee, is now a staff member of the U.S.P.H.S. Doctor Thompson is a fellow of the A.C.H.A.

Deaths

Anne Y. Peebles, for eighteen years director of nursing at the Woman's Hospital, Detroit, and organizer of the obstetric department of Illinois Central Hospital, Chicago, died recenly.

Edith Atkin, director of nursing at St. Luke's Hospital, New York City, until her retirement some time ago on account of ill health, died in New York last month.

Trustees

Morris Kurtzon, president of Mount Sinai Hospital, Chicago, for twenty-six years, has been elected chairman of the board. **Leopold Kling** succeeds Mr. Kurtzon as president.

THE BOOKSHELF

The Snake Pit. *By Mary Jane Ward. New York: Random House,* 1946. $2.50.

Believing that an experience which could be expected to drive a normal person out of his mind might also shock the mentally afflicted back to normalcy, medieval healers used to lower these sufferers into snake pits—hence the title of this revealing novel about a mental disease hospital. The story is told with simple objectivity; no obvious attempt is made to arouse the reader's sympathy, yet no person can read these pages without a deepening sense of shame that sick and suffering human beings can be treated so inhumanly here today.

There is never a moment's doubt that this is an authentic picture. The wards, numbered from one to 33 according to the degree of "disturbance" of the patients; the nurses—a few with warmth and understanding, many who are indifferent to the patients' needs, one who is diabolically cruel; the tunnels through which patients are led, or herded, from one building to another; the terrifying confusion of the mess halls; the sinister baths and wet packs for patients in hydrotherapy; the pitiless shock treatments; the bewildering interviews with doctors—all these, and a hundred other details, are too vividly portrayed to be anything but real.

Convincing, too, is the heroine's mental imbalance. Through snatches of recollected experience the life pressures which contributed to her illness are gradually presented, bringing the reader finally to the disquieting realization that her mental processes differ from those we call "normal" by only the sheerest margin. Here is an evaluation of mental illness that is worth a hundred textbooks and learned articles, a feeling of oneness with the confused patient during the agonizing periods when she has no recollection for time or place, or even for her deeply beloved husband, and during the breath-taking moments when she sees her whole situation with complete clarity and delightful good humor.

Of course, this is the author's own story, as she has frankly acknowledged and the publishers state on the jacket. The mentally ill and their families and friends owe a great debt to her courage in writing it. It is likely to stand with the work of Dorothea Dix and Clifford Beers as a contribution to the understanding of mental illness and improvement in the treatment of mentally ill patients. And, unlike their work, it is going to be read by millions.—R. M. Cunningham Jr.

Handbook for Psychiatric Aides: *Section 1: A General Guide to Work in Mental Hospitals. Edited by Frank L. Wright Jr. Philadelphia: National Mental Health Foundation,* 1946. Pp. 58. $0.50.

This classification and description of all that is known about the causes, symptoms and treatment of the principal forms of mental disease, written in simple lay terms, would seem to be required reading for employes of mental disease hospitals or general hospitals that accept psychiatric patients. The whole discussion is aimed at bringing the reader a fuller understanding of the patients entrusted to his care; in each case specific suggestions are added outlining the needs for physical and psychological assistance of typical patients in the various categories.

A 10 page section at the back of the book presents a capsule history of psychiatry from the time the mentally ill were thought to be visited with demons down to the present, a bibliography of lay books and journals on psychiatric subjects and a useful glossary of psychiatric terms.